

**HCFA REGIONAL OFFICES:
INCONSISTENT, UNEVEN, UNFAIR**

HEARING
BEFORE THE
SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE
ONE HUNDRED SIXTH CONGRESS

FIRST SESSION

WASHINGTON, DC

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THURSDAY, NOVEMBER 4, 1999

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The committee met, pursuant to notice, at 10:02 a.m., in room SD-562, Dirksen Senate Office Building, Hon. Charles E. Grassley (chairman of the committee), presiding.

Present: Senators Grassley, Craig, Breaux, Wyden, Reed, Bryan, and Lincoln.

OPENING STATEMENT OF SENATOR CHARLES GRASSLEY, CHAIRMAN

The CHAIRMAN. While we are giving our opening statements, I will ask the witnesses to come to the table so that even though we have not introduced you yet, you will be there and we can save some time for that.

I am glad to call the hearing to order. It is a pleasure to welcome my colleagues and most importantly our witnesses, who are basic to every hearing, and those of you from the public at-large who are attending this hearing, some of whom I know are very regular attendees at our hearings.

For more than 2 years now, our committee has heard stories from residents and their family members about poor treatment in nursing homes. We in this committee, whether in this forum or in other forums, have worked to change the system. We have had a series of hearings and forums to bring many of these issues to the public's attention. We have secured millions of additional dollars for the enforcement system. And in the final analysis as it deals with nursing homes, we simply wanted to put an end to bedsores, malnutrition and dehydration.

The obvious question at this point is whether we have been successful. Can we assure the American public and particularly nursing home residents and their families that there are better conditions? Can we ease the anxiety of those who must place their family members into nursing homes?

When it comes right down to answering that question, if we are going to be candid, we have to say: Not really; not yet. In a sense, think of our nursing home enforcement system as a diseased tree. The Health Care Financing Administration has cut down dead branches, plucked off sickly leaves; the ailing tree trunk and its diseased roots are still intact, and anything that grows from the

anemic base is tainted. So until we cut down the tree, we are going to get nothing but bitter fruit.

The ailing tree trunk is the weak use of enforcement tools by HCFA. Eighteen months ago, the General Accounting Office documented this problem, and the Clinton administration pledged to fix it. One specific fix was that the Federal Government should cutoff funding to States that do a bad job of inspecting their nursing homes. Another fix was that the Federal Government should do a better job of monitoring State inspections of nursing homes.

Who is responsible for seeing to it that the States inspect nursing homes properly? Of course, it is the HCFA regional office administrators. And over the past year, the General Accounting Office has told us how poorly HCFA's regional offices have performed in oversight of Medicare contractors, of Medicaid school-based programs and of Medicare+Choice programs. Now the GAO is telling us the regional office problem spills over into State agency evaluations. These evaluations are inconsistent, uneven, and unfair. They do not tell the truth about how a State survey program works or does not work.

Today the General Accounting Office tells us that HCFA has never terminated a contract with a State inspection agency and that it has reduced the State inspection funding only once.

Part of the reason for these minimal sanctions is HCFA's lack of an adequate way of knowing whether States are fulfilling their duties or not. Obviously, a punishment must fit the crime, and if the regional offices cannot evaluate the States, HCFA cannot punish them for failures.

Today I hope we will hear how HCFA plans to address these problems. I hope to hear about a swift and sound plan of correction. Like many Americans, I do not understand why the greatest Nation on the face of the Earth cannot make sure that nursing homes are cleaned up once and for all.

Our first witness is Dr. William Scanlon, Director of the Health Financing and Public Health Issues area of the U.S. General Accounting Office. He has directed the GAO's analysis of nursing homes at our committee's request.

Our second witness is Steve White, chief of licensure and certification in North Carolina. He represents the Association of Health Facility Survey Agencies in his capacity as that organization's immediate past president.

We also welcome Mr. Michael Hash, Deputy Administrator of HCFA, who will be our final panelist. I want to thank Mr. Hash for being here today. Members of this committee were quite disturbed in March when HCFA did not attend our hearing to hear what citizens had to say about the inadequacies of HCFA's complaint investigation process. So we do appreciate your presence as part of this panel and look forward to HCFA's participation in the committee's future events.

Senator Breaux.

STATEMENT OF SENATOR JOHN BREAUX

Senator BREAUX. Thank you very much, Mr. Chairman.

I think you have adequately described what we are attempting to do this morning and what we want to hear from GAO and from

our State representatives, as well as from HCFA. Having HCFA, the Government representatives, testify last is not intended to slight the Federal agency. I remember when I was in the House and chaired a committee back in the old days when Democrats were in charge, I used to always ask the administrative witnesses to come to the hearings and appear last so they could hear the testimony presented by others and have the opportunity to completely respond. I thought that that worked very well, and I am sure it will this morning as well.

I think that as this committee has continued to supervise the Medicare program and look at Medicaid and how the money is being spent, it becomes clearer and clearer to me that it is going to be really necessary to bring about wholesale and true reform of the Medicare program. It has just gotten so complicated, and this is one example of why it almost becomes physically impossible to coordinate an agency of this size and do it very well.

Medicare has 135,000 pages of regulations, about three times more than the Internal Revenue Code, and we all know how complicated that is. So what we are finding in all of these areas, I think, is a very large bureaucracy, which we have created, which is attempting to do the job that Congress has said it has to do but finding some real serious problems in being able to achieve that goal. And I think that what we have here is an example of that, and structural reform may not be what we need to do in order to make it run more efficiently and effectively for the people whom it is designed to serve.

I look forward to the witnesses' presentations.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

I will call on Senator Craig and then Senator Wyden and then Senator Reed.

STATEMENT OF SENATOR LARRY CRAIG

Senator CRAIG. Mr. Chairman, thank you very much for holding this hearing this morning.

It is also fun to join with the ranking member, Senator Breaux, who is now the star of the seniors tennis circuit.

Senator BREAUX. I am just a senior.

Senator CRAIG. Just a senior. Well, I think that any time anyone gets his name in a national newspaper for some kind of athletic prowess, that is stardom.

Anyway, Mr. Chairman, I do want to thank you for holding this hearing to search out what appear to be discrepancies between the Health Care Financing Administration's regional offices and their application of those policies.

I would also like to thank each of our witnesses for taking the time to be before this committee this morning to testify.

Like probably everyone else, I support effective efforts to oversee and improve the quality of care of our elderly and what they are receiving through our nursing homes. However, I am a bit concerned about HCFA's implementation of nursing home initiatives, particularly the evaluation of State agency performance and penalties associated with HCFA's enforcement of survey activities.

After speaking with several folks in my home State of Idaho in preparation for this hearing, including the executive director of the Idaho Health Care Association which represents 78 of the 87 skilled nursing facilities, I am concerned that the survey process is inconsistent and is being enforced differently amongst the various HCFA regions and States. According to OSCAR data, Idaho, Oregon, and Washington, all in Region 10, are consistently worse in terms of survey statistics than the rest of the Nation. I must tell you, Mr. Chairman, that I do not have a trained eye, but I visit five, six, seven, nursing homes a year in my State concerned about quality of health care delivery, and I must tell you that what I see, at least from a layman's point of view, appears to be quality care being delivered.

The chief of the Bureau of Facility Standards in Idaho repeatedly tells me that he would be glad to hold any of our facilities in Idaho up against any facility in any other State; yet Idaho's survey numbers would suggest that Idaho's skilled nursing facilities are among the worst in the Nation.

I understand that HCFA has several different types of surveys in place, including the Federal monitoring survey, the comparative survey, and the observational surveys. But if the central office does not require consistent standards of the evaluations from region to region or State to State, I question the credibility of these efforts.

How is HCFA able to accurately assess the State agencies' performance without good comparative data—something as simple as the number of hours spent on any particular survey or the ratio of State supervisors to one Federal supervisor may differ from region to region.

Again, I would like to thank you, Mr. Chairman, and our panel of witnesses today. I believe that consistency among the different regions and States is critical to maintaining, or in this case to improving, our health care delivery system.

Thank you.

[The prepared statement of Senator Craig along with prepared statements of Senator Reid and Jeffords follows:]

PREPARED STATEMENT OF SENATOR CRAIG

I'd like to thank the Chairman for holding this hearing today on the discrepancy between the Health Care Financing Administration's (HCFA's) regional offices and their application of HCFA's policies. I would also like to thank each of the witnesses for taking the time to appear before the committee to testify.

Like probably everyone else here, I support effective efforts to oversee and improve the quality of care our elderly are receiving in the Nation's nursing homes. However, I am a bit concerned about HCFA's implementation of nursing home initiatives, particularly the evaluation of state agency performance and penalties associated with HCFA's enforcement of survey activities.

After speaking with several folks in my home State of Idaho, including the executive director of the Idaho Health Care Association, which represents 78 of Idaho's 87 skilled nursing facilities, I am concerned that the survey process is inconsistent and is being enforced differently among the various HCFA Regions and States. According to OSCAR data, Idaho, Oregon and Washington (all from Region 10) are consistently worse, in terms of survey statistics, than the rest of the nation. However, the Chief of the Bureau of Facility Standards in Idaho repeatedly says that he would gladly hold any facility in Idaho up against any facility in any other state. Yet, Idaho's survey numbers would suggest that Idaho's Skilled Nursing Facilities are among the worst in the Nation.

I understand that HCFA has several different types of surveys in place, including the Federal monitoring survey, the comparative survey, and the observational sur-

veys. But if the central office does not require consistent standards of the evaluations from region to region or state to state, I question the credibility of these efforts. How is HCFA able to accurately assess the state agency's performance without good comparative data? Something as simple as the number of hours spent on any particular survey or the ratio of state surveyors to one federal surveyor may differ from region to region.

Again I would like to thank the Chairman and our panel of witnesses here today. I believe that consistency among the different regions and states is crucial to maintaining, or in this case improving, our healthcare system.

Thank you.

PREPARED STATEMENT OF SENATOR HARRY REID

Good morning Mr. Chairman, members of the Committee, and guests. I am pleased that the Committee is continuing to examine the issues surrounding the quality of care provided to nursing home residents across the countries.

As a member of this Committee, I have participated in a number of hearings that have highlighted the poor quality of care and other problems that exist in many nursing homes. It is hard to forget the disturbing testimony we have heard from the families, nurses, doctors, and nursing home aides who witnessed nursing home abuse and neglect first-hand. An important lesson we have learned from these hearings is that there are significant weaknesses in the Federal and State programs charged with ensuring quality of care for nursing home residents.

As part of the Administration's strategy to ensure that all nursing home residents are treated with dignity and compassion, the Health Care Financing Administration (HCFA) has implemented a new Federal monitoring system to oversee the state monitoring of nursing home quality of care. I am pleased that we are taking a closer look at the implementation of this particular initiative, because a strong surveillance and enforcement system is crucial to ensuring the health and well-being of the nursing home residents in our states.

While I am pleased that HCFA is committed to improving enforcement in states with weak inspection systems, I am concerned that HCFA is not applying its oversight methods consistently across all of its regions. In my home State of Nevada, there is concern that our facilities are evaluated according to much stricter standards than nursing homes across the country. While I cannot emphasize enough the importance of a credible and rigorous survey process, it is also important that the survey process is fair and consistent across the country. I understand that the GAO report addresses this issue, and I look forward to hearing from HCFA today to learn what steps it is taking to improve this situation.

As the largest single payer of nursing home care, the Federal Government is charged with ensuring that our oldest, most vulnerable population receives quality care, and that our standards are strictly enforced. If we turn a blind eye to the serious lack of enforcement of nursing home standards in this country, we are no better than the facilities that condone negligent and abusive practices in their nursing homes. I hope that today's hearing will help HCFA to identify some of the trouble spots in this part of the nursing home initiative so it may continue its efforts to ensure that nursing homes meet quality standard.

PREPARED STATEMENT OF SENATOR JEFFORDS

I applaud the Chair for convening today's hearing on another part of the story important to our national effort to deliver quality nursing home care to frail and disabled adults. The Chair's strong leadership has been critical in providing the consistent, even, and fair examination of what needs improving to actualize the promises of the 1987 Federal Nursing Home Reform Act, commonly known as OBRA '87.

The Chair is not alone in his concern for quality nursing home care delivered by an effective regulatory system. In a recent survey conducted by Vermont's Department of Aging and Disabilities, 60 percent of Vermonters have concerns that a nursing home stay is in their future. Like all Vermonters, I want and need the State and Federal Governments to maximize the health, safety, welfare, and rights protections called for in State and Federal standards.

Today, we learned from the General Accounting Office, the Health Care Financing Administration (HCFA), and the Association of State Licensing and Survey Agencies that much needs to be done. HCFA's current data and oversight systems do not allow the Agency a reasonable ability either to monitor or to evaluate the actions of their own regional offices or of their contracted State agencies which conduct thousands of inspections. While the real-life outcome of such lapses in Government

oversight may be buried in jargon like the "FOSS" survey, the Federal Government's responsibility is to keep promises of quality health care which were made to the veterans of World War II and their children.

I take very seriously the responsibilities of Government to protect our citizens living in the Nation's 17,000 nursing homes. It is vitally important that Government be able to detect and remedy poor long-term care services with highly qualified, trained State and Federal inspectors carrying out tested national protocols.

I call upon all the witnesses at today's hearing and upon the advocates and providers who serve nursing home residents to work constructively to gather and evaluate all the data necessary to evaluate the quality of nursing home care. And it is equally important that advocates, providers, and governmental agencies work harder to assure that the care and services provided in all long-term care facilities honor our families, friends, and communities. We and they desire nothing less.

The CHAIRMAN. Thank you. I think you also ought to be applauded for visiting as many nursing homes as you do as well.
Senator Wyden.

STATEMENT OF SENATOR RON WYDEN

Senator WYDEN. Thank you, Mr. Chairman.

I too appreciate your holding this hearing. Back when I was director of the Gray Panthers at home in Oregon, I was the public member on the Board of Nursing Home Examiners, and we had a lot of these problems then. It is very clear, as the GAO reports to us today, that the problems are getting worse.

Nursing home surveys are now a crazy quilt of inconsistent practices with respect to the number of surveyors involved and the time that is spent on these surveys. To me, the message the GAO has furnished the committee today is that there are no practical tools for measuring the quality of nursing home care in this country. That is what we have got to address, and one area that I am particularly interested in examining, Mr. Chairman—and I am very pleased that you and Senator Breaux deal with all of these matters on a bipartisan basis—is trying to put in place a system that allows us to devote a special focus on those facilities that are causing the bulk of the problems.

It is very clear—and this is frankly true in any field, whether it is law or accounting or the U.S. Congress or any other institution—that you have a fraction of the people in the institutions that you have to devote special attention to. I would hope that we could look at creating what amounts to a watch list for facilities that, on an ongoing basis, are showing that they are not complying with the quality standards that we need. If you have a watch list so that you can focus on the 5 percent or whatever the number is and ensure that they get the rigorous kind of treatment that is necessary to monitor for quality care, it seems to me you send a message all through the field that you are going to do what is necessary to promote good quality, and at the same time, you are not going to say to the majority of facilities—and Senator Craig is absolutely right, there are a lot of facilities that give good care; we see them in the West—we ought to create a system that allows us to put the focus of our resources in terms of monitoring and enforcement on those facilities that are clearly not performing in terms of quality. I hope that in the days ahead, we can talk in this committee about the idea of creating a watch list so that on an ongoing basis, those facilities that are not performing get special scrutiny, and there is an

effort to make sure that they are in compliance, and also use the privilege to offer care with reimbursement from the Government.

So I look forward to working with the committee and to hearing from our witnesses.

The CHAIRMAN. Thank you, Senator Wyden.

Senator Reed.

STATEMENT OF SENATOR JACK REED

Senator REED. Thank you, Mr. Chairman, and I thank you very much for holding this hearing. I think it is very important to try to assess the relationship between the HCFA central office and the regional offices.

I have heard many of the same complaints that my colleagues have heard about the unfair application of standards, the variations between States and regions, the fact that within the industry, there are certain standards applied in one place that are applied differently in other places. We all believe in standards and the need for them, but we equally believe that these standards should be as uniform as possible, as fair as possible, and as effective and efficient as possible.

I believe that this hearing and the gentlemen who are here with us today can help us better understand what is going on and better ensure that we have uniform and effective standards for the nursing home industry.

I thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Reed.

Now, Senator Lincoln.

STATEMENT OF SENATOR BLANCHE L. LINCOLN

Senator LINCOLN. Thank you, Mr. Chairman, and as always, we appreciate your leadership and Senator Breaux' leadership on this issue.

We would like to welcome you gentlemen to our committee. I believe that today, we are building on several other hearings that this committee has held to assess the ability of HCFA to monitor and improve the quality of care in nursing homes as part of the Nursing Home Initiative.

I am very interested in hearing from our witnesses about how HCFA's central office coordinates with its regional offices in overseeing State surveys and applying penalties to States that do not comply with Federal regulations.

I do not think that the purpose of this hearing is to point fingers or to criticize; rather, I think my colleagues and I hope to identify the barriers within HCFA that prevent coordination and oversight at the regional and State levels, hopefully, encouraging the right hand to speak to the left hand and know what each other are doing.

We also need to know what obstacles State survey agencies face in order to conduct surveillance and enforcement activities. The only way we can help in solving those problems is to understand what it is that you are faced with.

The ultimate goal of all of our efforts is to ensure that our seniors are safe and well-cared for in our skilled nursing facilities. As Chairman Grassley said in a previous hearing on nursing home

oversight, over 90 percent of all nursing homes are doing a fine job. It is that 5 to 9 percent of the bad apples that we really want to weed out, and I think that is what this hearing is about.

In closing, this is not just a HCFA problem. It is not just a State survey agency problem. I think we all must work together to improve the present oversight system. And based on today's testimony and questions, I think we can all make recommendations for improvement and work together to find those solutions. Our seniors certainly deserve nothing less in this country.

Thank you, Mr. Chairman, for your leadership. We appreciate it and look forward to the testimony.

The CHAIRMAN. And I thank so many of my colleagues for turning out for this hearing, and not just for this hearing, but most of the time, we have very good attendance, and as Chairman, I really appreciate that, but more importantly, I think it shows the concern of Members of the Senate about the conditions in nursing homes and our desire to do something about it.

I have already introduced the witnesses, so we will start with Dr. Scanlon, then Mr. White, and then Administrator Hash, please.

STATEMENT OF WILLIAM J. SCANLON, DIRECTOR, HEALTH FINANCING AND PUBLIC HEALTH ISSUES, U.S. GENERAL ACCOUNTING OFFICE, WASHINGTON, DC

Mr. SCANLON. Thank you very much, Mr. Chairman and Members of the Committee. I am very happy to be here today to discuss HCFA's regional offices and their ability to oversee the State agencies that the Federal Government contracts with to ensure that nursing homes comply with Federal quality standards.

Today we are releasing a report that we prepared at your request that evaluates HCFA's programs for the oversight of these agencies.

The hearings that this committee has had, as you indicated, Mr. Chairman, over the past 24 months have highlighted both the disturbingly frequent instances of unacceptably poor care that many nursing home residents receive, as well as weaknesses in the Federal and State programs to detect, correct, and prevent such care.

This attention has helped to generate a renewed commitment by HCFA, including a broad range of about 30 initiatives that it has undertaken, as well as actions by many States to improve their programs to ensure that nursing homes meet quality standards.

This summer, we testified that the initial implementation of some of HCFA's initiatives has been uneven across the country, and successful implementation will require continued commitment on the part of the Congress, HCFA and the States.

In the report being released today, we found that HCFA's mechanisms for assessing State agency survey performance are limited in their scope and effectiveness and are not being applied consistently across each of HCFA's 10 regional offices. As a result, HCFA does not have sufficient and consistent data to evaluate State agencies or to measure the success of its other initiatives to assure nursing home quality.

Presently, there is a wide range in the frequency with which States identify serious deficiencies in nursing home care, as Senator Craig has indicated. HCFA cannot be certain, however, wheth-

er States with lower rates of deficiencies have better-quality homes or are just failing to identify deficiencies that harm nursing home residents.

In our view, this uncertainty results in part because HCFA makes negligible use of independent inspections, known as comparative surveys, that could provide information on whether States appropriately cite deficiencies. HCFA only conducted between one and three comparative surveys per State over the last year. Nevertheless, more than two-thirds of these surveys found deficiencies that were more serious than those found by the State surveyors that typically had been in the home one or 2 months earlier.

Rather than making extensive use of comparative surveys, HCFA instead conducts 90 percent of its surveys as observational surveys in which regional office surveyors accompany and observe State surveyors as they conduct all or a portion of a nursing home survey. Observational surveys may help HCFA identify State agency training needs, but several problems inhibit their ability to provide a clear and accurate picture of State survey performance. Perhaps most importantly, HCFA's presence during the survey may make State surveyors more attentive to their tasks than they would be if they were not being observed. It is a well-established fact that individuals are very likely to improve their performance or behavior when they are aware they are being studied.

To assure that State agencies are fulfilling other aspects of their quality assurance activities, HCFA relies on State-operated quality improvement programs, largely based on self-reported performance measures. As an oversight program, its effectiveness is limited because HCFA does not validate the information included in the State self-assessments. As a result, HCFA has no assurances that States identify or correct all serious problems. For example, in our prior work, we found that some States were not promptly reviewing complaints filed against nursing homes, but had not identified this problem to HCFA as required by the quality improvement program.

These limitations of HCFA's oversight mechanisms are compounded by inconsistencies in how the mechanisms are applied by the 10 regional offices. For example, the regions vary in how they select which nursing home surveys to review and the sample of residents in those reviews. Regions also commit differing amounts of time to observational surveys, ranging on average from 27 to 71 hours per survey, raising questions about whether the level of effort in some regions is sufficient. Our testimony this summer also highlighted that regions varied widely in how they monitored State implementation of HCFA's nursing home initiatives.

You asked us, Mr. Chairman, to examine whether or not HCFA's organizational structure may play a role in this inconsistency across regions, and your staff has prepared a chart of HCFA's organizational structure, on my left. I would note that HCFA relies on its 122 surveyors in the 10 regional offices to carry out the oversight responsibilities that I have been discussing. While HCFA's Center for Medicaid and State Operations is the central office division responsible for developing guidance to the regions and the States, the regional office staff is responsible for nursing home oversight, and they are not directly accountable to the Center. Rather, they report to a regional administrator who, through the

four consortia of regions, reports directly to the HCFA Administrator.

Setting appropriate priorities, providing guidance on policies, and assuring effective implementation involves extensive coordination and cooperation between the Center and the regions. Such an arrangement can work, but it relies on there being excellent coordination and cooperation between the Center and each region as well as a commonality of purpose. When disagreements arise that cannot be settled informally, they can only be resolved at the level of the HCFA Administrator.

Apart from the issues related to whether HCFA identifies inadequate State agency performance is the question of what HCFA can do to correct poor performance. HCFA currently does not have an adequate array of effective remedies or sanctions to ensure correction. Generally, HCFA provides training to surveyors or survey teams, or requires that States submit a plan of correction. If these remedies fail, HCFA has two sanctions available—reducing a State's survey and certification funding, or terminating its survey contract. Because of the extreme nature of both, it would be rare to invoke either. Indeed, HCFA has only reduced State funding on one occasion and has never terminated a State contract. Furthermore, HCFA's current oversight structure does not effectively provide the evidence on State performance that the agency would need to justify applying such sanctions.

Let me conclude by noting that in our view, assuring that the State survey agencies are fulfilling their responsibilities is essential if the efforts that this Committee has triggered to eliminate the too frequent instances of poor nursing home care are to succeed. Measuring State agency performance is a key first step in knowing where to concentrate assistance and influence to improve performance. Significantly increasing the use of comparative surveys would help to provide the information needed to direct such efforts.

Consistency among the regions in the oversight of State agencies is important in order to further facilitate the targeting of efforts to improve performance. Consistency among the regions is also essential, as we discussed in June, for the implementation of the full array of initiatives that HCFA has undertaken. The promise of those initiatives will not be realized if they are not fully deployed in all States.

Finally, while recognizing the difficulty of the task, we would encourage HCFA to continue to work to develop additional remedies or sanctions for State agencies whose performance is not adequate to protect their residents from poor nursing home care.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions that you or members of the Committee may have.

The CHAIRMAN. Thank you very much.

[The prepared statement of Mr. Scanlon follows.]

United States General Accounting Office

GAO

Testimony

Before the Special Committee on Aging, U.S. Senate

For Release on Delivery
Expected at 10:00 a.m.
Thursday, November 4, 1999

NURSING HOMES

HCFA Should Strengthen Its Oversight of State Agencies to Better Ensure Quality Care

Statement of William J. Scanlon, Director
Health Financing and Public Health Issues
Health, Education, and Human Services Division



Mr. Chairman and Members of the Committee:

We appreciate the opportunity to participate in the Committee's hearing focusing on HCFA's regional offices and their ability to oversee state agencies they contract with to ensure that nursing homes comply with federal quality standards. Today, I will discuss our study of HCFA's implementation of two of its nursing home initiatives: one requiring enhanced federal review of state agencies' survey process, and the other addressing remedies and sanctions to be applied when inadequate state performance is identified.

The 1.6 million elderly and disabled residents of the nation's more than 17,000 nursing homes are among the sickest and most vulnerable populations in the nation, often needing extensive assistance with basic activities of daily living such as dressing, grooming, feeding, and using the bathroom. In 1999, these nursing homes are expected to receive nearly \$39 billion in federal payments from the Medicare and Medicaid programs. To help ensure that they provide proper care to their residents, state agencies, under contract with the federal government, perform detailed inspections at each of the homes. The purpose of these state agency surveys is to ensure that nursing homes comply with federal quality standards and that inadequate resident care is identified and corrected. HCFA, in turn, is statutorily required to make sure that each state agency has an effective survey process in place.

The series of hearings this Committee has held over the past 15 months has highlighted both the disturbingly high frequency of unacceptably poor care that many nursing home residents receive as well as weaknesses in federal and state programs charged with ensuring quality care. This has helped to generate a renewed commitment by HCFA and many states to improve their programs to ensure that nursing homes meet quality standards, including a broad range of about 30 initiatives that HCFA has undertaken to strengthen federal standards, oversight, and enforcement for nursing homes. In reports issued at the Committee's request since July 1998, we have documented the severity of care problems nationwide and inadequacies in the survey and enforcement process that too often leave these problems unidentified or uncorrected, and have made recommendations to strengthen HCFA's oversight of nursing homes.¹ This summer, we testified that the initial implementation of some of HCFA's initiatives has been uneven among the states and will require continued commitment by the Congress, HCFA, and the states.²

The focus of today's hearing is HCFA regional offices' oversight of state agencies that perform the surveys of nursing homes, addressing issues fundamental to ensuring that homes meet federal care standards protecting residents and that the states adhere to the new, stronger federal policies resulting from HCFA's nursing home initiatives. The

¹A list of related GAO products is at the end of this statement.

²Nursing Homes: HCFA Initiatives to Improve Care Are Under Way but Will Require Continued Commitment (GAO/T-HEHS-99-155, June 30, 1999).

information we are presenting here discusses HCFA's progress in implementing two important initiatives to improve its state oversight. In a report we are releasing today, we provide more detailed information.³

In brief, we found that HCFA's mechanisms for assessing state agency survey performance are limited in their scope and effectiveness and are not being applied consistently across each of HCFA's 10 regional offices. As a result, HCFA does not have sufficient, consistent, and reliable data to evaluate state agencies or to measure the success of its other nursing home initiatives. Given the wide range in the frequencies with which states identify serious deficiencies, HCFA cannot be certain whether states with lower rates of deficiencies have better quality homes or are failing to identify deficiencies that harm nursing home residents.

This uncertainty results, in part, because HCFA makes negligible use of independent inspections, known as comparative surveys, that could surface information about whether states appropriately cite deficiencies. Generally, only one to two comparative surveys per state were conducted in the more than 17,000 nursing homes over the last year. Nevertheless, two-thirds of these surveys found deficiencies that were more serious than those found by state surveyors during their reviews conducted typically 1 or 2 months earlier. About 90 percent of the inspections HCFA conducts nationwide are, instead, observational surveys. These surveys, in which HCFA surveyors accompany state survey teams, are useful in helping HCFA to provide training to state surveyors, but are limited as a method for evaluating state agencies' performance. HCFA's presence during these surveys is likely to make state surveyors more attentive to their survey tasks than they would be if they were not being observed--the Hawthorne effect. Beyond these surveys, HCFA also relies on a quality improvement program that is largely based on states' self-reported performance measures, which do not accurately or completely reflect problems in the state's performance.

These limitations in HCFA's oversight methods are compounded by inconsistencies in how the methods are applied by its regions. For example, the regions vary in how they select nursing home surveys to review and how they choose samples of residents to review. Regions also commit differing amounts of time to conduct observational surveys, ranging on average from 27 to 71 hours, which raises questions about whether the level of effort some regions dedicate to observational surveys is sufficient to thoroughly review state surveyors' performance.

Furthermore, for state agencies whose performance has been found inadequate, HCFA has not developed a sufficient array of alternatives to encourage agencies to correct serious deficiencies in their processes. Our report includes several recommendations to assist the HCFA Administrator in improving the rigor, consistency, and effectiveness of HCFA's programs to oversee state agencies responsible for certifying that nursing homes meet federal standards for participation in Medicare and Medicaid.

³See Nursing Home Care: Enhanced HCFA Oversight of State Programs Would Better Ensure Quality (GAO/HEHS-00-6, Nov. 4, 1999).

BACKGROUND

On the basis of statutory requirements, HCFA defines standards that nursing homes must meet to participate in the Medicare and Medicaid programs and contracts with states to certify that homes meet these standards through annual inspections and other types of reviews, including complaint investigations. The annual inspection, which must be conducted no less than every 15 months at each home, entails a team of state surveyors spending several days on-site conducting a broad review to determine whether care and services meet the assessed needs of residents. HCFA has established specific protocols for state surveyors to use in conducting these comprehensive reviews.

HCFA is statutorily required to establish an oversight program for evaluating the adequacy and effectiveness of each state's nursing home survey process, relying on its 122 surveyors in 10 regional offices to carry out these oversight responsibilities. While HCFA's Center for Medicaid and State Operations is the central HCFA division responsible for developing guidance to states embodying national policies related to nursing home oversight and enforcement, the regional officials who oversee the state survey agencies are not formally subordinated to this Center. Rather, they report to a Regional Administrator. The 10 regions are further organized into 4 regional consortia, and both the regional consortia heads and the Director of the Center for Medicaid and State Operations report directly to HCFA's Administrator.⁴ In addition to developing overall policy guidance, the Center's staff carry out their day-to-day role of coordinating regional office oversight of the states through numerous less formal interactions with regional officials, including meetings and conference calls between managers and staff from the Center and the regions. If a disagreement between the Center and a regional office cannot be informally settled at a lower level, it can only be resolved at the level of the HCFA Administrator.

The Omnibus Budget Reconciliation Act of 1987 requires HCFA's surveyors to conduct federal monitoring surveys in at least 5 percent of the nursing homes in each state each year within 2 months of the state's completion of its survey. HCFA uses a mix of two types of on-site reviews to fulfill this 5-percent mandate: (1) comparative surveys, in which a team of federal surveyors conducts a complete, independent survey of a nursing home after the state has finished its survey and compares the state's survey results with its own, and (2) observational surveys, in which federal surveyors accompany and observe the state surveyors as they perform a variety of survey tasks, give state surveyors verbal feedback, and later provide a written rating of the state surveyors' performance to state managers. HCFA introduced revisions in its federal monitoring program in October 1998 that require a minimum of 1 to 3 comparative surveys in each state each year and that also developed a standard set of procedures all regions are expected to follow in

⁴The regional consortia play an important role in administering HCFA policies in other HCFA functions, such as oversight of the Peer Review Organization program and Medicare+Choice plans. In these areas, most functions have been consolidated into one of the two or three regional offices in the consortium. However, each of the 10 regional offices carries out the full range of functions relating to oversight of state agencies' implementation of HCFA's guidance relating to nursing homes.

conducting an observational survey. In addition to the comparative and observational surveys, HCFA has other sources of information available for evaluating state agency performance, including a quality improvement program that requires state agencies to establish performance measures and develop action plans addressing deficiencies in the state's survey process.

If HCFA determines that a state agency's survey performance is inadequate, it can impose appropriate remedies or sanctions against the state agency. Among several remedies and sanctions HCFA can use currently are requiring the state to submit a written plan of correction explaining how it plans to eliminate the identified deficiencies, reducing federal funds for state survey and certification activities, and ultimately, terminating HCFA's contract with the state.

To assess HCFA's oversight activities, we obtained data about federal monitoring surveys and other oversight efforts from HCFA and each of its 10 regions, interviewed officials at HCFA headquarters and 3 of its regions, and met with state surveyors from four states (Florida, Missouri, Tennessee, and Washington).

HCFA MAKES NEGLIGIBLE USE OF COMPARATIVE SURVEYS TO ASSESS STATE AGENCIES' PERFORMANCE

An effective HCFA program for assessing state agencies' performance in certifying that nursing homes meet federal standards for quality care is especially important given concerns that some state agencies miss serious care problems. Our work in California found that surveyors missed some problems that affect the health and safety of residents. In addition, HCFA data show significant variations in the extent to which state surveyors identify serious deficiencies. For example, state survey agencies in Washington, Idaho, North Dakota, and Kansas identified serious deficiencies resulting in harm to residents in more than half their surveys—more than 4 times the rate of serious deficiencies found by survey agencies in Maine, Colorado, Tennessee, and Oklahoma. With such a range, HCFA needs to know to what extent such data accurately portray the quality of care provided or the adequacy of state performance in the survey process.

However, HCFA makes negligible use of comparative surveys—*independent re-surveys of homes*—which are its most effective technique for determining whether state surveyors miss deficiencies. HCFA requires that only 1 or 2 of these surveys be completed each year in most of the states. Yet, more than two-thirds of the 64 comparative surveys HCFA conducted between October 1998 and August 1999 identified more serious deficiencies than the state identified.

For example, in one of its comparative surveys, surveyors from HCFA's Kansas City region found 24 deficiencies in a Missouri nursing home that state surveyors did not identify during their survey conducted about 6 weeks earlier. One of these deficiencies identified six residents whose nutritional status was not being adequately assessed by the nursing home, resulting in significant weight loss in several cases. One resident lost 19 percent of his weight between June and October 1998. His weight at the time of HCFA's

survey was 93 pounds, which HCFA indicated was significantly below the resident's minimally acceptable body weight of 108 pounds. Fewer than 4 months after his admission to the nursing home, this resident also had developed two moderately severe pressure sores, which the home was inappropriately treating with a cream the manufacturer stated was not intended to heal pressure sores but rather to prevent irritation to the skin. According to HCFA surveyors, these deficiencies affecting multiple residents should have been evident at the time of the state's survey, but the state surveyors did not cite them.

Because of the time that typically elapses between a state's survey and HCFA's comparative survey, HCFA often cannot be certain whether HCFA-identified deficiencies are the result of poor state agency performance, such as state surveyors' failure to identify deficiencies, or to changed conditions in the nursing home following the state survey. Typically, these surveys occur 1 month after the state completes its survey but sometimes occur as much as 2 months later. In August 1999, HCFA instructed its regions to start comparative surveys within 2 to 4 weeks after the state's survey, but even this delay could result in problems comparing results. State and federal surveyors told us that comparative surveys are more effective and reliable in assessing state performance if they start immediately after the state has completed its survey, even as soon as the day after the state's exit from the home.

Rather than making more extensive use of comparative surveys, HCFA instead conducts 90 percent of its surveys as "observational" surveys, in which its regional surveyors accompany and observe state surveyors as they conduct all or a portion of their survey. These observational surveys may help HCFA to identify state agency training needs, but several problems inhibit their ability to give a clear and accurate picture of a state's survey capability. Perhaps most importantly, HCFA's presence may make state surveyors more attentive to their survey tasks than they would be if they were not being observed. This is an example of the Hawthorne effect, in which individuals tend to improve their performance when they are aware they are being studied. As a result, observational surveys do not necessarily provide a valid assessment of typical state surveyor performance.

Another HCFA oversight mechanism, which predates HCFA's recent nursing home initiatives, also has significant shortcomings. Under the State Agency Quality Improvement Program, each state does a yearly self-assessment and informs HCFA as to whether it is in compliance with seven survey requirements, such as investigating complaints effectively. As an oversight program, its effectiveness is limited because HCFA does not validate the information included in the states' self-assessment as was required under this program's predecessor, and thus has no assurance that the states surface all serious problems or that they correct all the problems they have identified. For instance, in our prior work we found that some states were not promptly reviewing complaints filed against nursing homes, yet they had not identified this problem to HCFA as part of their quality improvement program.⁵ In addition, HCFA has no policy regarding consequences for states that do not provide accurate information through this

⁵GAO/HEHS-99-80, Mar. 22, 1999.

program. Furthermore, although the program also addresses some state agency performance standards that must be reviewed by HCFA's staff, these standards do not include some important aspects of a state agency's performance, such as determining whether the timing of a state agency's surveys can be predicted by the nursing homes.

HCFA REGIONS ARE INCONSISTENT IN HOW THEY CONDUCT OVERSIGHT ACTIVITIES

In addition to these weaknesses in its oversight mechanisms, HCFA regions are uneven in the way they implement them, resulting in limited assurance that states are being held equally accountable to federal standards, including the recent initiatives. Although HCFA established the current federal monitoring surveys to develop a uniform national approach for regions to follow, the regions use different methods for selecting surveys to review and for conducting reviews. Examples follow:

- Some regions comply with HCFA guidance on comparative surveys by selecting homes with no established pattern of deficiencies, while other regions focus on homes that the state has already identified as having serious deficiencies. By doing the latter, HCFA is unlikely to identify situations in which state surveyors underreport serious deficiencies. Furthermore, HCFA's broad guidance for selecting observational surveys does not ensure that its reviews assess as many state surveyors as possible to maximize the training effect.
- In conducting comparative surveys, the regions vary in how they select resident samples, with some regions selecting a sample that includes some overlap with the state's sample and other regions making no attempt to do so.
- The regions also, on average, spend very different amounts of time to conduct an observational survey. While the average time spent on these surveys is 52 hours, the regions range from an average of 27 hours to 71 hours to conduct these surveys, thus raising questions about the level of effort some regions devote to gauging state performance. Table 1 provides additional detail on the variation in regional resources available and in the time spent to complete observational surveys.

Table 1: Variation in Resources Available and in Time to Complete Observational Surveys

Region	Ratio of state to federal surveyors	Ratio of observational surveys required in 1999 to federal surveyors	Average no. of hours per observational survey (Oct. 1998 - July 1999)
Boston	14 to 1	5 to 1	27
New York	33 to 1	7 to 1	31
Philadelphia	16 to 1	6 to 1	49
Atlanta	33 to 1	7 to 1	61
Chicago	31 to 1	8 to 1	71
Dallas	60 to 1	10 to 1	38
Kansas City	30 to 1	6 to 1	51
Denver	18 to 1	4 to 1	59
San Francisco	27 to 1	8 to 1	54
Seattle	16 to 1	3 to 1	52
Nationwide	28 to 1	7 to 1	52

In addition, HCFA regional officials make different use of the State Agency Quality Improvement Program for overseeing state agency performance. Some regions supplement information provided by the states through the quality improvement program by extensively analyzing available survey performance data, while other regions do not believe there is a need to use these supplemental data to assess state survey performance. For example, HCFA's Atlanta region recently started a program to conduct in-depth analyses of each state agency in its region using available survey data. Through these analyses, the region determined that the annual state surveys of nursing homes in four of its eight states are highly predictable, contrary to HCFA policy. It also found that in four of the six states where it has completed reviews, more than half of the time state surveyors did not conduct revisits of nursing homes, to determine whether identified deficiencies had been corrected, within the 55 days recommended by HCFA.

In testimony before your Committee this summer, we also noted that the HCFA regions do not consistently monitor state implementation of new, stronger policies resulting from HCFA's nursing home initiatives. When we asked the regional offices how they were monitoring states' implementation of these initiatives, their responses ranged from no monitoring of most of the implemented initiatives to requiring states to submit special monthly reports on how they were implementing several of the initiatives. These uneven monitoring practices, combined with the limitations we found in HCFA's more formalized monitoring approaches, result in HCFA not being sufficiently informed about what the states are doing to implement these initiatives.

HCFA'S OPTIONS FOR ADDRESSING POORLY PERFORMING STATE AGENCIES ARE INADEQUATE

Even if HCFA identifies inadequate state agency performance, it currently does not have an adequate array of effective remedies or sanctions to ensure corrections. Most commonly, HCFA provides training to surveyors or survey teams. HCFA may also

require the state to submit a plan of correction, provide technical assistance, and assume responsibility for developing the state's survey schedule. If these remedies fail, HCFA has two sanctions available that it may then apply--reducing a state's survey and certification funding or terminating its survey contract. Because of the extreme nature of these sanctions, HCFA has only once reduced state funding and has never terminated a state's contract.

To support reducing the state's survey and certification funding, HCFA requires evidence showing a pattern of inadequate state performance, which its current oversight structure does not effectively provide. In essence, HCFA must show that a state agency demonstrates a pattern of failing to identify serious deficiencies. However, because HCFA conducts so few comparative surveys, and observational surveys are not intended to identify all missed deficiencies, it is not currently possible for HCFA to establish that a state consistently fails to identify serious deficiencies.

As part of its nursing home initiatives, HCFA established a task force in late 1998 to expand and clarify the definition of inadequate state survey performance and to suggest additional remedies and sanctions for state agencies that perform poorly. The task force has preliminarily proposed two additional sanctions for HCFA's use: (1) placing a state agency on notice that it is not in compliance with its Medicaid plan regarding nursing home survey performance and (2) requiring HCFA officials to meet with the governor and other high-level state officials. Although HCFA refers to these two proposed actions as sanctions, they are not as severe as what are normally thought of as sanctions and may not be forceful enough to compel a state to improve its performance. Regarding placing the state agency on notice, we were told that it means that HCFA expects its regions to work collaboratively with state agencies to urge compliance with the requirements in their state Medicaid plans. Furthermore, although the proposed sanction requiring HCFA officials to meet with the governor or other state officials can raise problems to a higher level in state government and possibly secure greater state support to improve performance, it is not clear what effect this sanction would have in compelling a state agency to improve its performance. HCFA intends to have these two new sanctions in place by the end of 1999. HCFA also plans to issue additional state survey agency performance standards and measures, and indicated that over the next 18 months, it will determine whether the expanded remedies and sanctions have been effective in improving state agency performance. At that time, HCFA will determine whether additional remedies or sanctions should be developed.

HCFA SHOULD STRENGTHEN ITS OVERSIGHT OF STATE PROGRAMS

HCFA has taken many positive steps--including 30 wide-ranging initiatives--that demonstrate its commitment to improving the quality of care that nursing home residents receive. These steps include a major effort to enhance its oversight of state agencies, but the limited scope and rigor of its various state performance monitoring mechanisms, and their uneven application across the regions, do not give HCFA a systematic, consistent means of assessing state survey performance. Specifically, the negligible use of comparative surveys, combined with delays in starting them, does not provide HCFA with sufficient evidence to determine whether states are appropriately assessing nursing

homes' compliance with federal standards. Furthermore, inconsistencies among the regional offices in their oversight of state agency performance hamper HCFA's ability to ensure that all state agencies are being held equally accountable for their performance. Even though HCFA is strengthening its oversight mechanisms to be able to establish a pattern of unacceptable state survey performance, it has not developed effective alternatives for ensuring that states meet federal standards.

Our report issued today contains several specific recommendations to HCFA to strengthen its oversight of state survey agencies' activities. These recommendations are intended to help HCFA ensure that states meet federal standards for certifying that nursing homes provide adequate care and consistently implement the more stringent standards required by HCFA's recent initiatives. Our recommendations include that the HCFA Administrator

- **Improve the scope and rigor of HCFA's oversight process** by increasing the use of comparative surveys and ensuring that they are initiated more promptly after states' surveys.
- **Improve the consistency of HCFA oversight across regional offices** by standardizing procedures for selecting and conducting federal monitoring surveys.
- **Further explore the feasibility of appropriate, alternative remedies or sanctions** for those states that prove unable or unwilling to meet HCFA's performance standards.

In reviewing a draft of our report, HCFA reaffirmed that enhanced oversight of state programs is critical to improving the quality of care in nursing homes and generally agreed with our recommendations. Although HCFA indicated that it needs to further evaluate the appropriate course of action, it is clear that HCFA's continued efforts and initiatives, in concert with the Committee's ongoing oversight, have the potential to make a decided difference in the quality of care for the nation's nursing home residents.

Mr. Chairman, this concludes my statement. I will be happy to answer any questions that you or other Members of the Committee may have.

GAO CONTACT AND ACKNOWLEDGMENTS

For further contacts regarding this testimony, please call William J. Scanlon or Kathryn G. Allen at (202) 512-7114. Individuals making key contributions to this testimony included John Dicken, Jack Brennan, and Mary Ann Curran.

RELATED GAO PRODUCTS

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

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

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

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

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

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

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

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GAO

United States General Accounting Office

Report to the Special Committee on
Aging, U.S. Senate

November 1999

NURSING HOME CARE

Enhanced HCFA Oversight of State Programs Would Better Ensure Quality



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GAO/HEHS-00-6



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

Health, Education, and
Human Services Division

B-281750

November 4, 1999

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

The federal government and the states are jointly responsible for ensuring that the nation's more than 17,000 nursing homes provide adequate care to their highly vulnerable 1.6 million elderly and disabled residents. The Health Care Financing Administration (HCFA), within the Department of Health and Human Services, is responsible for ensuring that each state establishes and maintains a survey capability that effectively identifies and resolves problems in nursing homes that receive Medicare or Medicaid payments. Under contract with HCFA, state agencies conduct surveys at nursing homes to ensure that the homes provide quality care to residents. On the basis of their surveys, these agencies certify to the federal government that each home is in compliance with federal nursing home standards, which enables the home to receive federal payments. Federal payments to these nursing homes under the Medicare and Medicaid programs are expected to total \$39 billion in 1999.

In previous reports to you, we found that residents received an unacceptably poor quality of care in some nursing homes and that the federal and state programs designed to identify and correct these problems had significant weaknesses. For example, we reported that

- nearly a third of the 1,370 homes in California had been cited for care violations classified as serious under federal or state deficiency categories;¹
- one-fourth of the nation's nursing homes had serious deficiencies that caused actual harm to residents or that placed them at risk of death or serious injury and that 40 percent of these homes had repeated serious deficiencies;²
- serious complaints alleging that nursing home residents are being harmed can remain uninvestigated for weeks or months, prolonging situations in

¹California Nursing Homes: Care Problems Persist Despite Federal and State Oversight (GAO/HEHS-98-202, July 27, 1998).

²Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards (GAO/HEHS-99-46, Mar. 18, 1999).

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which residents may be subject to abuse, neglect resulting in serious care problems like malnutrition and dehydration, preventable accidents, and medication errors;³ and

- when serious deficiencies are identified, federal and state enforcement policies have not been effective in ensuring that the deficiencies are corrected and remain corrected.⁴

In response to these problems and our recommendations, HCFA has developed about 30 initiatives to strengthen federal standards, oversight, and enforcement for nursing homes.⁵ One of these initiatives is to enhance federal oversight of the state survey agencies to help ensure that the states are adequately protecting the health and safety of nursing home residents. When it is determined that a state agency is not adequately performing its survey responsibilities, HCFA has indicated it would develop appropriate sanctions to penalize the state agency, including terminating its contract. HCFA's initiatives are fundamental to its ability to hold states accountable for reliably and consistently performing their contractual responsibilities for certifying that nursing homes meet Medicare and Medicaid standards and provide quality care for nursing home residents.

Because an effective oversight program is critical to HCFA's ability to gauge the states' success in implementing HCFA's many initiatives, you asked us to evaluate HCFA's oversight programs of state agencies' nursing home survey process. Specifically, we assessed (1) the effectiveness of HCFA's approaches to assessing state agency performance, (2) the extent to which HCFA's regional offices vary in their application of these approaches, and (3) the corrective actions available to HCFA when it identifies poor state agency performance. To do this work, we contacted HCFA's 10 regional offices to obtain data about each region's oversight programs from 1996 to the present; interviewed officials at HCFA's headquarters in Baltimore as well as federal surveyors and their managers in HCFA's regional offices; interviewed HCFA officials from the Atlanta, Kansas City, and Seattle regions and met with state surveyors and their managers in four states from these three regions—Florida, Missouri, Tennessee, and Washington; and reviewed data provided by HCFA and its regional offices regarding the number and types of oversight reviews conducted during the past 3 years. We conducted our work between March and September 1999 in accordance with generally accepted government auditing standards.

³Nursing Homes: Complaint Investigation Processes Often Inadequate to Protect Residents (GAO/HEHS-99-80, Mar. 22, 1999).

⁴GAO/HEHS-99-46, Mar. 18, 1999.

⁵A list of related GAO products is included at the end of this report.

Results in Brief

Since last year, HCFA has undertaken a series of initiatives intended to address quality problems facing the nation's nursing home residents, including redesigning its program for overseeing state agencies that survey nursing homes to ensure quality care. The objective of HCFA's oversight program is to evaluate the adequacy of each state agency's performance in ensuring quality care in nursing homes, but the mechanisms it has created to do so are limited in their scope and effectiveness. In addition, HCFA's oversight mechanisms are not applied consistently across each of its 10 regional offices. As a result, HCFA does not have sufficient, consistent, and reliable data to evaluate the effectiveness of state agency performance or the success of its recent initiatives to improve nursing home care. Given the wide range in the frequencies with which states identify serious deficiencies, HCFA cannot be certain whether some states are failing to identify serious deficiencies that harm nursing home residents. Furthermore, HCFA does not have an adequate array of effective sanctions to encourage a state agency to correct serious or widespread problems with its survey process.

HCFA's primary mechanism to monitor state survey performance stems from its statutory requirement to survey annually at least 5 percent of the nation's 17,000 nursing homes that states have certified as eligible for Medicare or Medicaid funds.⁹ But HCFA's approach to these federal monitoring surveys does not produce sufficient information to assess the adequacy of state agency performance. To fulfill its 5 percent monitoring mandate, HCFA makes negligible use of its most effective technique—an independent survey done by HCFA surveyors following completion of a state's survey—for assessing state agencies' abilities to identify serious deficiencies in nursing homes. For the vast majority of states, HCFA requires only one or two of these comparative surveys per state, per year. Yet, in the 64 comparative surveys conducted from October 1998 to August 1999, HCFA found deficiencies that were more serious than those the state found in about two-thirds of the surveys, which suggests that some state surveyors miss some serious deficiencies. But because of elapsed time between the federal and state surveys, HCFA cannot tell whether the differences between its survey results and those of the state are attributable to poor state performance, such as underreporting by state surveyors, or to conditions in the nursing home that changed since the state survey. Rather than making extensive use of comparative surveys, HCFA focuses 90 percent of its own survey efforts on "observational

⁹The Omnibus Budget Reconciliation Act of 1987 refers to the surveys HCFA must conduct as "validation surveys." HCFA's broad term for validation surveys is "federal monitoring surveys," which consist of comparative and observational surveys. Under HCFA's current federal monitoring surveys, observational surveys are technically referred to as Federal Oversight and Support Surveys.

surveys," in which it relies on its regional surveyors to observe state surveyors as they conduct at least a portion of their surveys. While this approach is useful in many respects, including identifying training needs for state surveyors, it also has a serious limitation as a way to evaluate state performance. HCFA's presence may make state surveyors more attentive to their survey tasks than when they are not being observed (the Hawthorne effect); therefore, this approach does not necessarily provide a valid assessment of typical performance.

A second HCFA oversight mechanism also has significant shortcomings. About 3 years ago, HCFA implemented the State Agency Quality Improvement Program (SAQIP), a program under which the state agency does a self-assessment to inform HCFA, at least once a year, whether the state is in compliance with seven standard requirements. For instance, all states are expected to evaluate their surveyors' ability to correctly document deficiencies in nursing homes and to conduct complaint investigations effectively. SAQIP is limited as an oversight program, however, because HCFA (1) does not independently validate the information that the states provide, so it is uncertain whether all serious problems are identified or whether identified problems are being corrected, and (2) has no policy regarding consequences for states that do not comply. For example, in our prior work, we found that some states were not promptly reviewing complaints filed against nursing homes and that these states had not identified this problem in their SAQIP reports to HCFA.⁷ SAQIP also includes four indicators of state performance that HCFA, rather than the states, assesses. SAQIP specifies, for example, that HCFA will determine whether states conduct nursing home surveys within specific time frames and enter the survey results into HCFA's database. However, the four indicators do not address some important aspects of a state agency's performance, such as the predictability of the timing of state surveys.

In addition to these weaknesses in its oversight programs, HCFA regions are uneven in the way they implement them, resulting in limited assurance that states are being held equally accountable to federal standards, including the recent initiatives. Although HCFA established the current federal monitoring surveys to develop a uniform national approach for regions to follow in conducting federal oversight surveys, the regions use different methods for selecting oversight reviews and conducting them. Some regions, for instance, comply with HCFA guidance to select homes with no established pattern of deficiencies, while other regions focus on

⁷GAO/HEHS-00-80, Mar. 22, 1999.

homes that the state has already identified as having serious deficiencies. Regions that take the latter approach are unlikely to identify situations in which state surveyors underreport serious deficiencies. The regions also, on average, spend very different amounts of time on observational surveys. While the average time spent on these surveys is 52 hours, the regions range from about 27 hours to about 71 hours to complete these surveys, thus raising questions about the level of effort some regions devote to gauging state performance. In addition, HCFA regional officials have varying views about SAQIP's effectiveness as an oversight program. As a result, some regions supplement SAQIP information by extensively analyzing available survey performance data, while other regions do not believe there is a need to use these supplemental data to assess state survey performance.

Even if HCFA identifies inadequate state agency performance, it currently does not have a sufficient array of effective remedies or sanctions at its disposal to ensure adequate state performance. When HCFA identifies poor state agency survey performance, it can employ one or more of several remedies, such as requiring the state to submit a plan of correction or providing special training to the state surveyors. If these remedies do not bring the state agency into compliance with survey standards, HCFA has two sanctions available—reducing a state's survey and certification funding or terminating the agency's survey contract. Because of the extreme nature of these sanctions, HCFA has only once reduced state funding and has never terminated a state agency's contract. Although HCFA is considering additional sanctions, on the basis of our review of them, we believe that their potential to compel a state to improve its performance is doubtful.

To assist HCFA in effectively overseeing state agencies and achieving the goals of its broader initiatives, we are recommending that HCFA improve the scope and rigor of its state oversight mechanisms, improve the consistency of its oversight across its regions, and further explore the feasibility of additional remedies and sanctions for states that prove unable or unwilling to meet HCFA's performance standards.

Background

HCFA is required by statute to establish an oversight program for evaluating the adequacy and effectiveness of each state's nursing home survey process.⁵ If HCFA determines that a state agency's survey performance is inadequate, it is authorized to impose appropriate remedies or sanctions

⁵See sections 1819 (g)(3) and 1919 (g)(3) of the Social Security Act.

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against the state agency. Among HCFA's remedies and sanctions are requiring the state to submit a written plan of correction explaining how it plans to eliminate the identified deficiencies; reducing federal funds for state survey and certification activities; and, ultimately, terminating HCFA's contract with the state. HCFA surveyors in its 10 regional offices carry out the oversight of state agencies.

Every nursing home that receives Medicare or Medicaid funding must undergo a standard survey conducted by the state agency no less than every 15 months. This survey entails a team of state surveyors spending several days on-site conducting a broad review of whether the care and services delivered meet the assessed needs of the residents.⁹ The Omnibus Budget Reconciliation Act of 1987 (OBRA 87) requires HCFA surveyors to conduct federal oversight surveys in at least 5 percent of the nursing homes in each state each year within 2 months of the state's completion of its survey.¹⁰ The following table shows the number of nursing homes per HCFA region, the number of federal monitoring surveys each region is required to conduct in fiscal year 1999, and the number of federal surveyors who conduct nursing home monitoring surveys as of August 1999.

Table 1: Nursing Homes, Required Federal Surveys, and Federal Surveyors Available, by HCFA Region

Regional office	Nursing homes	Federal monitoring surveys required to meet 5% requirement in fiscal year 1999	Federal nursing home surveyors available as of August 1999
Boston	1,170	63	12
New York	1,020	56	7
Philadelphia	1,526	84	12
Atlanta	2,772	139	18
Chicago	3,784	189	22
Dallas	2,398	122	11
Kansas City	1,693	84	12
Denver	666	37	8
San Francisco	1,681	89	11
Seattle	497	32	9
Total	17,207	895	122

⁹The standard survey is used to meet HCFA's requirement to certify homes for Medicare and Medicaid participation.

¹⁰A minimum of five reviews must be conducted in each state each year, even if this brings the total number of required reviews to more than 5 percent.

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HCFA's recent initiatives relating to assessing state agency performance are the latest in a series of approaches HCFA has used since OBRA 87 was enacted. Until 1992, HCFA conducted only comparative surveys, in which federal surveyors performed an independent survey of a home and compared their results with the state's. Since 1992, HCFA has used a mix of comparative and different variations of observational surveys. For instance, from 1992 until July 1995, the regions used surveys in which they directly observed individual state surveyors as they performed a survey, but did not communicate with them until the last day of the survey. Starting in 1995, HCFA regional surveyors observed the state surveyors and actively communicated with them during the survey. Under this approach, federal surveyors provided on-the-spot training to the state surveyors. Starting in July 1996, HCFA allowed the regions to develop variations of this approach, and by 1998, multiple regional variations existed. Among these were partial observational surveys that focused on only parts of the survey, and participatory surveys in which federal surveyors became members of the state agency teams.

As part of its broader nursing home initiatives, in October 1998 HCFA introduced its current program of overseeing state survey agency performance, referred to as the federal monitoring survey. This program modified HCFA's prior oversight programs and has two components. The first component is a comparative survey, in which a team of federal surveyors conducts a complete, independent survey of a nursing home after the state has completed its survey, and then compares the results with the state's.¹¹ The second component, which is HCFA's primary monitoring technique, is an observational survey, in which generally one or two federal surveyors accompany state surveyors to a nursing home either as part of the home's annual standard survey or as part of a revisit or a complaint investigation.¹² During these observational surveys, federal surveyors watch the state surveyors perform a variety of tasks, give the surveyors verbal feedback, and later provide a written rating of the state surveyors' performance to state managers. Basically, the current observational surveys represent an extension of the several types of observational surveys that HCFA's regions have used over the previous 6 years. However, unlike earlier observational surveys, the revised surveys are intended to have a national standard protocol, a national focal point

¹¹In conducting these surveys, state and federal surveyors must use the survey protocol (that is, the set of survey procedures) as set out in HCFA's regulations.

¹²Revisits are surveys that are required after a nursing home has been found to have certain deficiencies, in order to determine whether the home has corrected the deficiencies. A complaint investigation is made when a complaint has been filed against the home.

for collecting data about the surveys, and a single national database for tracking survey results.

In addition to the formal review activities required under the federal monitoring surveys, HCFA has other sources of information available for evaluating state agency performance. One such source, SAQIP, initiated in 1996, requires states, in partnership and collaboration with HCFA, to develop and implement quality improvement action plans to address deficiencies in the state's survey process that either the state or HCFA has identified. In addition to SAQIP, a few regions also use information from HCFA's database on survey results to assess state performance in areas such as timeliness of providing information to nursing homes regarding identified deficiencies and the timeliness of enforcement actions.

Limitations Hinder HCFA Oversight Programs' Effectiveness in Assessing State Survey Performance

HCFA's current strategy for assessing state agency survey performance has limitations that prevent HCFA from developing accurate and reliable assessments. The number of comparative surveys required to be completed each year is negligible in that only one or two are required in most of the states, and over half of the comparative surveys are started more than a month after the state completes its survey. Observational surveys are also limited in their effectiveness because these tend to cause state surveyors to perform their survey tasks more attentively than they would if federal surveyors were not present (the Hawthorne effect), thus masking a state's typical performance. Observational surveys have also had other problems during their first year of implementation, such as the fact that federal surveyors are not required to observe state surveyors performing most survey tasks, the lack of an effective data system for recording results, and the slowness of written feedback to state surveyors. Finally, SAQIP does not require independent verification of states' self-reported performance, and its standards do not address all important aspects of the state survey process.

HCFA's Use of Comparative Surveys Is Negligible

Although comparative surveys are the only oversight tool that furnishes an independent federal survey where results can be compared with those of the states, HCFA's use of them is negligible. Conducting a sufficient number of these comparisons is important because of concern that some state survey agencies miss significant problems. For example, HCFA surveyors found deficiencies that were more serious than those found by the state surveyors in about two-thirds of the comparative surveys they conducted between October 1998 and July 1999.

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As we reported in July 1998, state agency surveyors can miss problems that affect the health and safety of residents.¹³ In addition, HCFA data show significant variation in the extent to which state surveyors identify serious deficiencies. For example, state survey agencies in Idaho, Kansas, North Dakota, and Washington identified serious deficiencies in more than half of their surveys. On the other hand, state surveyors in Maine, Colorado, Tennessee, and Oklahoma identified such problems in only 8 to 13 percent of their surveys.¹⁴ With such a range in identified serious deficiencies in nursing homes, HCFA needs to know to what extent such data accurately portray the quality of care provided or the adequacy of state survey agency performance.

Of the 64 comparative surveys that HCFA completed between October 1998 and July 1999, 44 (69 percent) identified a more serious deficiency than had the state surveyors. For example, during a comparative survey conducted at a nursing home in Missouri in November 1998, HCFA found 24 deficiencies that it believes state surveyors should have, but did not, identify during their review about 6 weeks earlier. One of these deficiencies identified six residents whose nutritional status was not being adequately assessed by the nursing home, resulting in significant weight loss to several of them. One resident lost 19 percent of his weight between June and October 1998. His weight at the time of HCFA's survey was 93 pounds, which HCFA indicated was significantly below the resident's minimally acceptable body weight of 108 pounds. Less than 4 months after this resident's admission to the home, he had also developed two moderately severe pressure sores, which the nursing home was inappropriately treating with a cream that its manufacturer stated was not intended to heal pressure sores but rather to prevent irritation to the skin.

Until 1992, comparative surveys were the sole method HCFA used to carry out state agency oversight responsibilities. According to HCFA documents, the agency began to decrease its reliance on comparative surveys in 1992 because (1) it was difficult to adjust for changes in the nursing home that may have arisen between the dates of the state and the federal surveys, (2) two separate surveys during a short time period created a strain on the nursing home, (3) too much time had passed between the completion of the state survey and the time the state received feedback from federal surveyors for the state surveyors to recall the details of the survey, and (4) comparative surveys were resource-intensive.

¹³GAO/HEHS-06-202, July 27, 1998.

¹⁴Based on standard surveys conducted between January 1997 and April 1999.

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Under the revised federal monitoring surveys, started in October 1998, HCFA acknowledged the need to do more comparative surveys than the 21 that had been done over the previous 2 years. Nevertheless, under this program, only about 10 percent of the federal monitoring surveys completed each year must be comparative surveys, and the remaining 90 percent may be observational surveys. Specifically, HCFA now requires a minimum of one comparative survey in states having fewer than 200 nursing homes, two in states with 200 to 599 nursing homes, and three in states with 600 or more homes. Table 2 shows the minimum number of comparative surveys to be completed in each state and the District of Columbia.

Table 2: Minimum Number of Comparative Surveys Required Yearly, by State

Number of homes in state (as of May 1999)	Minimum number of comparative surveys required each year	Number of states	States
Fewer than 200	1	20	Alaska, Arizona, Delaware, District of Columbia, Hawaii, Idaho, Maine, Montana, Nevada, New Hampshire, New Mexico, North Dakota, Oregon, Rhode Island, South Carolina, South Dakota, Utah, Vermont, West Virginia, Wyoming
200 to 599	2	24	Alabama, Arkansas, Colorado, Connecticut, Georgia, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, New Jersey, North Carolina, Oklahoma, Tennessee, Virginia, Washington, Wisconsin
600 or more	3	7	California, Florida, Illinois, New York, Ohio, Pennsylvania, Texas

While providing important information, the low number of comparative surveys will not permit HCFA to determine how representative these one to three surveys per state are of overall state performance.

Gap in Time Between State Survey and HCFA Comparative Survey Makes Assessment of State Performance Difficult

HCFA reestablished the comparative survey as part of its oversight survey process in 1998, but it has not adequately addressed the earlier concern about the time that elapses between the end of the state's survey and the start of the federal survey. We found that 33 days on average passed between these dates for comparative surveys completed from October 1998 through July 1999. Although this meets the requirements of OBRA 87, the gap in time between the two surveys raises the possibility that changes at the nursing home between the two surveys were responsible for differences, thus calling into question the extent to which federal results can be used to assess state performance.

OBRA 87 requires HCFA to start a comparative survey in a nursing home within 2 months of the completion of the state's survey. HCFA's conclusions about the state's survey effectiveness are supposed to take into account the difference in time. Because aspects of a nursing home, such as residents, staffing, and ownership, can change in a short period of time, developing a fair and accurate assessment of state surveyor performance after a lapse in time can be difficult. Several state and HCFA surveyors we interviewed told us that the time lag between the surveys continues to be a problem. Our analysis shows that for the 64 comparative surveys that HCFA completed between October 1998 and July 1999, 33 days, on average, had passed from the time the state completed its survey until HCFA started its comparative survey. Sixty-three of these comparative surveys started within the 2-month time frame mandated by OBRA 87, while only one, which started 68 days after the state's survey, did not.¹⁵ Four regions averaged fewer than 30 days, with the Dallas and Denver regions averaging 17 days. At the other end of the scale, the Atlanta and New York regions averaged 43 days, while the Philadelphia region averaged 47 days. Table 3 shows the number and time frames of comparative surveys conducted between October 1998 and July 1999.

¹⁵The median time for the start of the 64 comparative surveys was 32 days.

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Table 3: Time Frames for the Start of the 64 Comparative Surveys HCFA Conducted Between October 1998 and July 1999

Days from end of state survey to start of comparative survey	Number of comparative surveys
0 to 10	7
11 to 20	10
21 to 30	12
31 to 40	12
41 to 50	10
51 to 60	8
Over 60	5

To avoid the problems presented by gaps in time between the state and federal surveys, in August 1999 HCFA instructed its regions to start comparative surveys within 2 to 4 weeks after the state's survey, because the less time that elapses between the two surveys, the less likely it will be that a home's environment, staff, or residents will have changed. While this is an improvement, a delay of several weeks in the comparative survey could still result in problems. State and federal surveyors told us that comparative surveys are more effective and reliable in assessing state performance if they start immediately after the state has completed its survey, even as soon as the day after the state's exit from the home.

Observational Surveys' Effectiveness Hindered by Systemic and Transitional Problems

HCFA relies on observational surveys as its primary federal monitoring technique. Observational surveys may help HCFA to identify state agency training needs on a real-time basis, but several problems inhibit these surveys from getting a clear and accurate picture of a state's survey capability. As designed, the surveys have a systemic weakness in that they require federal surveyors to observe state surveyors as they conduct a survey. Because they know they are being observed, state surveyors may be more attentive to survey tasks than they would normally be. In addition to this weakness, HCFA has encountered several specific problems as it transitions from its previous types of observational surveys to those now being conducted. For example, the surveys (1) cannot identify all significant deficiencies that state surveyors miss, in part because HCFA surveyors are not required to observe most of the tasks state surveyors perform; (2) necessitate that one HCFA surveyor must oversee the efforts of as many as three state surveyors at one time; (3) rate state surveyors for some survey activities that are not required by federal survey regulations; and (4) have had serious data system problems that prevent HCFA from assessing the results of observational surveys conducted since October 1998. In addition, HCFA surveyors have not always given timely

written feedback to state agencies with respect to state surveyors' performance so that corrective action can be implemented promptly.

Unlike comparative surveys, observational surveys do not require HCFA surveyors to perform an independent review of a nursing home. Instead, HCFA surveyors observe state surveyors as they perform portions of a survey and rate them on one or more of eight possible survey tasks.¹⁶ As a result of observing only a portion of the survey, HCFA surveyors cannot determine whether state surveyors identify all significant deficiencies. HCFA officials told us that observational surveys were not designed to identify all deficiencies. They also said that of the 631 observational surveys completed between October 1998 and August 1999, only 8 (1 percent) identified deficiencies that were more serious than those identified by the state.¹⁷ During our interviews, nine of the regions indicated that observational surveys allow them to help state surveyors identify deficiencies that may otherwise be missed but that the surveys do not ensure that HCFA surveyors identify all serious deficiencies. The Kansas City region agreed with the other regions but also indicated that federal surveyors can identify deficiencies missed by state surveyors if they perform all eight survey tasks, as this region says it does, during an observational survey.

During an observational survey, federal surveyors are generally required to observe only two of the eight tasks—the preparation of the statement of deficiencies and the resident review and quality-of-life assessments.¹⁸ As a result, during any given survey, federal surveyors are not required to observe most of the survey tasks that state surveyors perform. Furthermore, some federal surveyors told us that even observing only the required tasks can be a problem because a single federal surveyor has sometimes been required to observe as many as three state surveyors at a time. Although HCFA guidance to the regions suggests that one federal surveyor should be able to observe the work of two or three state

¹⁶The tasks are to determine how well state surveyors perform (1) the off-site preparation activities, (2) the entrance conference, (3) the initial tour of the home, (4) the selection of a sample of residents for review, (5) the analysis of information they developed to determine deficiencies, (6) the exit conference, and (7) the preparation of the statement of deficiencies. An eighth task, with six subtasks, includes how well state surveyors observe general conditions of the home, kitchen and food service activities, care and treatment of several sampled residents, quality of life for selected sampled residents, administration of medications, and the adequacy of the home's internal quality assurance program.

¹⁷These eight surveys were all from the Kansas City region.

¹⁸Each region must address three of the eight tasks in a given percentage of yearly observational surveys. For instance, the sample selection task must be reviewed in at least 60 percent of the observational surveys completed in a state during the year.

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surveyors, federal surveyors we interviewed indicated that, in their experience, it is generally not possible for one federal surveyor to adequately observe more than two state surveyors at a time.

Several state surveyors expressed concern to us that some of the criteria HCFA used to assess their performance are inconsistent with the survey tasks required in federal guidelines. For example, although federal guidelines do not require an employee of the nursing home to accompany the state surveyors during the required tour of the home, a state surveyor in Florida told us that he was criticized for conducting the tour without an employee present. Officials from one HCFA region confirmed that such situations have occurred and attributed them to a flaw in the federal survey's protocol that does not distinguish between optional and required survey activities.

Inconsistencies between the federal guidelines and survey protocol increased when HCFA issued a revision to the guidelines on July 1, 1999. Some of these changes introduced significantly different survey requirements, such as a new methodology for state surveyors to use in selecting a sample of nursing home residents to review. A HCFA official acknowledged that inconsistencies have existed since revised observational surveys started in October 1998 and that the revision to the federal guidelines has added to the inconsistencies. She told us that one of several HCFA work groups now reviewing observational surveys is working to identify and eliminate the inconsistencies.

In addition, the data system developed to support the observational surveys has not been able to produce usable management reports. Because of technical problems with the system, HCFA regions were not able to enter survey results in the database for several months. As a result, HCFA has been unable to use the database to identify poorly performing state agencies or to determine needed corrective actions. The Dallas regional office found these problems particularly troublesome and told us that its surveyors are extremely frustrated with the database because it requires too much time to input data and does not allow easy access to the data that have been entered. As a result, the region has not been able to use the database to analyze the results of its surveys.

HCFA officials told us that problems with the data system occurred because HCFA rushed its development in order to meet the program implementation date of October 1998 and thus did not follow standard systems development practices. For example, a requirements analysis was not

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completed to ensure that the system would provide all the information HCFA would need to assess state performance. HCFA entered into a contract in June 1999 to address these problems and to add additional capabilities, including the creation of a new database for surveys conducted after October 1, 1999. However, the results of surveys conducted in fiscal year 1999 will not be included in the new database. Although a HCFA official told us that it would be unacceptable for regions not to consider survey results from the first year of the revised surveys in determining a state survey agency's performance, there has been no guidance from HCFA requiring the regions to consider information in both databases when assessing state performance. Moreover, the observational survey database is now maintained separately from the database that HCFA uses to track identified deficiencies in nursing homes. Although HCFA plans to include the results of observational surveys in its redesigned central database, this redesign will not take place for several more years, according to HCFA officials.

Finally, although formal written feedback is not required as part of observational surveys, the regions we visited provide feedback in this way to state agencies. To be useful, this feedback should be provided in a timely manner to both the state surveyors who performed the survey and their managers so that any needed corrective action can be taken. Nevertheless, in three of the four states we visited, the surveyors and their managers sometimes did not receive the written feedback for 3 to 5 months after the survey was completed. Furthermore, in some cases, state surveyors were surprised at the content of the written feedback because it was much more critical of their performance than the initial verbal feedback they received from HCFA surveyors during the survey. Although the revised surveys started in most states in October 1998, an official of the Association of Health Facility Survey Agencies testified that as of late June 1999, state agency managers from a majority of states had received no formal feedback. She further indicated that oversight without feedback is not effective in improving quality.¹⁹

Some state agency officials told us that HCFA's delays in providing written feedback have prevented the agencies from initiating important corrective actions when problems with state surveyor performance were identified. For example, for an observational survey conducted in Florida in October 1998, HCFA did not give feedback to the state until February 1999. This survey found, among other things, that the state surveyors did not correctly select the resident sample and that HCFA surveyors had to intervene to ensure that the sample was appropriate. For another survey

¹⁹Testimony before the Senate Special Committee on Aging, June 30, 1999.

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conducted in Florida in March 1999, HCFA gave feedback to the director of the state's survey program in early April 1999, but the state surveyors who participated in the review and their manager did not receive the written results until May 1999. In this survey, HCFA found that the state surveyors were too quick to accept explanations of apparent deficient practices by the nursing home's staff, thus permitting potentially deficient practices to continue.

SAQIP Does Not Provide HCFA With Complete State Agency Performance Data

In addition to the federal monitoring surveys that are required by statute, HCFA instructs its regions to use SAQIP to improve and monitor certain state agency survey-related activities. When a state is not in compliance with a SAQIP standard, HCFA is expected to help the state develop a corrective action plan and to work with the state as a partner to correct the problem. However, SAQIP cannot ensure that HCFA knows of significant problems in a state agency's activities because SAQIP relies on the state agency to self-certify to HCFA whether it is in compliance with particular requirements associated with its performance. Because HCFA does not independently verify the information the states provide, it has no assurance that states surface all serious problems or that they correct the problems they have identified. Although SAQIP also includes some indicators of state performance that HCFA itself assesses, these indicators do not address all the important aspects of a state agency's activities.

SAQIP replaced HCFA's State Agency Evaluation Program in 1996.²⁰ Under the previous program, HCFA's regions analyzed data maintained in HCFA's databases to evaluate some indicators of state performance and conducted on-site reviews at state survey agencies of state documentation to assess compliance with other indicators. For example, to assess a state's complaint process, regional surveyors visited the state to review state documentation from a sample of complaints filed against nursing homes and determine whether the state responded appropriately to the complaints. Each region was required to follow the same procedures in reviewing all state agencies, the states were rated on specific activities, and the results of each state's rating were compiled in a single report.

In essence, SAQIP includes nearly all of the same broad standards that the previous program included, but it shifts the responsibility for assessing compliance with seven standards from the regions to the states. SAQIP does not require that HCFA independently verify the state's assertion.

²⁰Both the State Agency Evaluation Program and SAQIP apply to all types of providers, including home health agencies, kidney dialysis facilities, nursing homes, and others.

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Compliance with the other four standards for nursing homes is determined by HCFA (see table 4).

Table 4: SAQIP Nursing Home Performance Standards for State Agencies

Responsible entity	Performance standards
State	<ul style="list-style-type: none"> — Properly document deficiencies discovered in a nursing home — Ensure that nursing homes' plans of correction accepted by the state agency reflect appropriate actions and time frames to correct cited deficiencies — Conduct all surveys with qualified individuals — Ensure consistency in survey performance — Measure the accuracy and improve the consistency in applying enforcement actions against nursing homes — Effectively investigate and process complaints filed against nursing homes — Monitor expenditures and support charges to federal programs in accordance with regulations
HCFA	<ul style="list-style-type: none"> — Ensure that each nursing home is subject to a standard survey not more than 15 months after its previous survey and that the statewide average between standard surveys does not exceed 12 months — Ensure that all surveys, including complaint investigations, are conducted unannounced or are announced consistent with HCFA instructions — Ensure that the state agency's annual budget request, activity plan, and expenditure reports are prepared and submitted in accordance with federal instructions and accurately reflect the allocation of costs between state and federal programs — Ensure that the state agency effectively maintains the database HCFA uses to record survey results

As a result of this change in SAQIP's design, HCFA has no assurance that a state is in compliance with the first seven standards. For instance, for the standard that requires states to "effectively investigate and process complaints filed against nursing homes," our March 22, 1999, report noted that Michigan's SAQIP acknowledged the state had not determined whether it was investigating and processing complaints in accordance with state time frames; yet, the state indicated that it believed it was doing so. When we reviewed the state documentation, we found that more than 100 pending complaints filed against Michigan nursing homes remained uninvestigated weeks and even months after their receipt, and that complaints that were investigated had not been investigated within Michigan's required time frames.²¹ The Atlanta regional office staff also told us that it identified more significant problems in a state when it used the previous evaluation program than it does using SAQIP. From this region's perspective, SAQIP does not provide for an in-depth evaluation of a

²¹GAO/HEHS-00-60, Mar. 22, 1999.

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state agency's survey or operational performance because it depends on a state's willingness to devote adequate resources for assessment and to be candid in identifying problems to HCFA.

In addition to removing HCFA's direct responsibility for verifying state compliance with the seven standards, SAQIP does not set national performance thresholds. For instance, under the previous evaluation program, HCFA reviewed a sample of deficiencies identified by the state survey agency to determine whether at least 90 percent of them were properly documented. If a state met this 90-percent threshold, its performance for this standard was acceptable. SAQIP leaves the determination of such thresholds to each state, and we found wide differences among states in the percentages they use. For example, in 1998, Oklahoma's goal was 75 percent, Louisiana's goal was 90 percent, and Wyoming's goal was 100 percent.

Regions Are Inconsistent in How They Conduct Oversight Activities

One of HCFA's goals in revising its federal monitoring surveys was to establish consistency among the regions in the process used to assess state performance. However, differences still exist among the regions in how they select and conduct oversight surveys. Although regions may need some flexibility in selecting surveys for review, conducting them requires a high level of consistency among the regions to ensure that states are being held equally accountable to federal standards. Additionally, HCFA regions differ in their view of SAQIP's effectiveness as an oversight tool, and some supplement HCFA's federal monitoring surveys and SAQIP by analyzing other available survey data to assess state agency performance. Finally, the regions spend very different amounts of time, on average, conducting observational surveys, which raises questions about the scope and quality of their reviews.

Regions Use Different Criteria and Methods for Selecting and Conducting Surveys for Review

When HCFA established the new federal monitoring survey in October 1998, it suggested that, for comparative surveys, the regions select homes for which the state did not find deficiencies categorized as "immediate jeopardy," "actual harm," or "substandard quality of care" (see app. I for definitions of these deficiency categories).²² However, only the Dallas, Denver, San Francisco, and Seattle regions indicated that they routinely follow this guidance. Other regions generally used a variety of other criteria, including selecting homes for which the state has identified

²²In commenting on a draft of this report, HCFA indicated that the focus of its comparative surveys for the next year will be on deficiency-free nursing homes.

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continuing serious problems or homes located in diverse geographic areas. Some regions also indicated that when conducting comparative surveys, they specifically select homes designated by HCFA for special focus because of the homes' poor performance histories.²³ By focusing on homes that were identified by state surveyors as having serious problems, HCFA's surveyors are less likely to identify situations in which state surveyors underreported serious deficiencies.

Another significant difference we found among the regions in conducting comparative surveys is the way they select a sample of nursing home residents for review. State surveyors select a sample of a home's residents as part of their procedures for evaluating the care and treatment given to the residents. For this sample, the surveyors may review a resident's medical record, interview residents and their relatives, and observe the environment and care practices of the home. Sample selection is a key survey task for determining whether a nursing home is in compliance with federal survey regulations and is providing appropriate care to its residents. In conducting a comparative survey, federal surveyors determine whether the state surveyors selected an appropriate sample of residents, and then also select a sample of residents as part of the comparative survey.

The regions vary in how they select resident samples, with some regions selecting a sample that includes some overlap with the state sample and other regions making no attempt to do so. For example, the Kansas City region tries to include in its sample one-half of the residents who were included in the state's sample, believing that this practice allows it to more closely duplicate the state's survey and thus obtain a more valid assessment of the state's performance. On the other hand, the Atlanta region makes no attempt to include any of the same residents in its samples, believing that if systemic care problems exist in a home, any sample will disclose these problems. We believe that, to better determine the reasons for discrepancies between comparative and state surveys, federal surveyors should sample as many of the same residents as the state sampled in cases in which federal surveyors determine that the state sample was appropriate. Federal and state surveyors we interviewed agreed that reviewing the same sample would improve the consistency of comparative surveys among HCFA's regions. However, they also noted that reviewing the same sample would require the comparative surveys to start much sooner than 2 months after the state's survey.

²³Homes selected by HCFA for special focus are those that continually have serious problems and require intense state agency monitoring as part of HCFA's nursing home initiatives. HCFA has designated two special-focus nursing homes in each state.

Each of the regions also uses a variety of criteria to select nursing homes for observational surveys. HCFA's guidance for selecting homes instructs the regions to use type, size, and geographic location of a nursing home, as well as to consider other criteria, including the performance differences among state survey offices in the region. Although observational surveys give HCFA an opportunity to provide on-site training to state surveyors, HCFA's guidance does not ensure that the regions will observe as many state surveyors as possible. For example, the Atlanta and Seattle regions indicated that surveys are often selected primarily on the basis of the characteristics of the nursing home and not in order to assess a broad range of state surveyors. At the time of our visit to the Atlanta region, it had completed seven observational surveys in two of Tennessee's three districts, but none in the third district. Furthermore, 7 of the 20 state surveyors reviewed during these surveys had been reviewed two or three times, while over two-thirds of Tennessee's surveyors had not been reviewed at all. The Atlanta region did not indicate any particular problem with the performance of these surveyors that would require repeated review of their performance.

Regions Differ in Their View and Use of SAQIP and Other Available Data

HCFA regions also vary in how valuable they believe SAQIP is as an oversight program. Some regions believe that SAQIP is effective, while others believe some SAQIP standards encourage states to improve the quality of their survey programs but other standards do not surface all serious problems. The Atlanta regional office told us that it does not believe SAQIP is an effective method for tracking and reporting operational problems in a state agency. Believing that SAQIP has limitations, some regions supplement it by analyzing data included in HCFA's databases to evaluate state agency performance in areas such as survey predictability.

The Seattle region, which played a major role in developing SAQIP, believes SAQIP is an effective oversight tool because it allows state agencies to identify survey performance problems unique to a state and permits the state agency to develop corrective action plans. The Philadelphia, Dallas, and Denver regions believe that some of the seven SAQIP quality improvement standards the states assess themselves are effective in encouraging states to improve their survey processes, but they also believe that the four remaining standards for which HCFA assesses performance are incomplete. For example, although one standard requires regions to review data to determine whether a state performs its surveys within statutory time frames, it does not require the regions to assess the same data to determine whether a state's survey schedule allows nursing homes

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to predict the date of their next survey. Avoiding predictability is important because the extent of care problems in a nursing home can be hidden if nursing homes can predict when their next survey will occur.

The Atlanta regional office recently started a program to conduct in-depth analyses of each state agency in its region by using available survey data. Through these analyses, the region recently determined that the annual state surveys of nursing homes in four of the region's eight states (South Carolina, Kentucky, Tennessee, and Mississippi) are highly predictable, contrary to HCFA policy. It also found that in most of the states where it has completed reviews, state surveyors were not conducting revisits of nursing homes to determine whether identified deficiencies have been corrected within HCFA's recommended time frame. Although HCFA recommends that a state wait no longer than 55 days to conduct its first revisit to a nursing home, four of the six states for which the Atlanta region completed reviews did not meet this time frame more than half of the time.²⁴ Table 5 presents the results of the Atlanta region's analysis of state time frames related to this requirement. The Atlanta region also found several problems with Florida's timeliness in conducting revisits, including one case in which state surveyors did not conduct a revisit until about 10 months after the home's original survey.

Table 5: Percentage of Surveys in Which First Revisit Was Not Made Within HCFA's Recommended Time Frame

State	Number of revisits conducted	Percentage of surveys in which first revisit was not made within HCFA's recommended time frame
Alabama (through Jan. 20, 1999)	21	76
Georgia (through Mar. 31, 1999)	105	77
Kentucky (through June 1, 1999)	108	22
Mississippi (through June 16, 1999)	69	61
North Carolina (through Apr. 20, 1999)	60	53
Tennessee (through Mar. 3, 1999)	84	10

After identifying problems with state performance, Atlanta officials meet with top-level survey and certification management officials in each state to discuss the results and present the data used to develop the findings. They then follow up this meeting with a formal letter to the state.

²⁴The Atlanta region had not completed comparable analyses of Florida or South Carolina at the time of our visit.

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summarizing the results of the meeting and identifying actions the region expects the state to take to correct identified problems. These management reports, which the Atlanta region plans to begin issuing quarterly, are expected to provide the region with a documented history of a state agency's performance over time, making it possible to more readily identify patterns of poor state performance.

Variation in Resources, Survey Time Across Regions

In addition to the variations among regions in the methods they use to conduct reviews, variations exist in the level of oversight resources available to them. Table 6 contains the ratio of state to federal surveyors, the ratio of observational surveys to be completed in fiscal year 1999, and the number of federal surveyors available to complete them. It also shows the average number of hours each region spent conducting surveys from October 1998 through July 1999.

Table 6: Variation in Resources Available for and Time to Complete Observational Surveys

Region	Number of federal nursing home surveyors (as of August 1999)	Ratio of state to federal surveyors	Ratio of observational surveys required in 1999 to federal surveyors	Average no. of hours per observational survey (Oct. 1998 - July 1999)
Boston	12	14.4 to 1	4.6 to 1	26.9
New York	7	33.3 to 1	7.1 to 1	31.0
Philadelphia	12	15.8 to 1	6.2 to 1	48.7
Atlanta	18	32.8 to 1	6.8 to 1	60.9
Chicago	22	30.7 to 1	8.0 to 1	70.6
Dallas	11	59.8 to 1	10.2 to 1	37.5
Kansas City	12	29.8 to 1	6.3 to 1	50.6
Denver	8	17.6 to 1	3.8 to 1	58.8
San Francisco	11	26.5 to 1	7.5 to 1	53.6
Seattle	9	15.7 to 1	3.0 to 1	51.6
Nationwide	122	28.3 to 1	6.6 to 1	52.2

Table 6 illustrates that federal surveyors in some regions must conduct significantly more observational surveys than surveyors in other regions. For example, at one extreme, Seattle surveyors are required to complete an average of 3 observational surveys per surveyor per year, while at the other extreme, Dallas surveyors must perform more than 10. Officials from the Dallas region told us that they did not have the resources available to complete the required review of 5 percent of state surveys in fiscal year

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1998 and indicated that the shortage would likely prevent them from meeting their survey requirements again in fiscal year 1999 unless they received help from other regions. The region attributed this shortage to the retirement of several surveyors at the end of the prior year, who had not yet been replaced, and the need to focus on other, higher-profile projects. A Dallas region official told us that the region plans to hire two more surveyors this year, but it will nevertheless need an additional four or five surveyors to meet its oversight requirements.

As shown in the last column of table 6, there are also large differences in the average time that regions have invested to complete observational surveys since October 1998, ranging from about 27 hours in the Boston region to nearly 71 in the Chicago region. HCFA officials could not explain the reasons for such variation. One official theorized that the variations might be due simply to differences in how the regions account for the time they spend conducting these surveys but also said that the variations could signify a difference in the content and quality of the surveys being performed.

HCFA's Options for Addressing Poorly Performing State Agencies Are Inadequate

Although HCFA has authority under the Social Security Act to take corrective action against a state agency that performs inadequately in conducting surveys, HCFA does not now have an adequate array of effective sanctions. HCFA may use several remedies to encourage a state to improve performance. When remedies fail, HCFA may impose either of two sanctions—reducing the state's funding for survey and certification activities or terminating the state's survey contract. However, HCFA has only once reduced a state's survey and certification funding for failure to conduct surveys in accordance with HCFA regulations, and it has never terminated a state's contract.²⁵ HCFA is considering regulations to authorize two additional actions that it classifies as sanctions, but, on the basis of our review of the proposed regulations, we believe their effectiveness is doubtful.

HCFA's Criteria for Applying Present Sanctions Limits Their Use

HCFA has the authority to take certain actions against a state agency that performs poorly.²⁶ Currently, HCFA defines inadequate state agency performance to include a state's failure to identify an instance in which

²⁵HCFA reduced survey and certification funding to the California state agency for its refusal to conduct surveys of nursing homes in 1990 and 1991 in accordance with OBRA 87.

²⁶See, for example, sections 1819 (d)(3)(C) and 1919 (d)(3)(C) of the Social Security Act.

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nursing home residents are placed in immediate jeopardy, or if a state agency demonstrates a pattern of other problems, including failure to

- identify deficiencies when the failure cannot be explained by changed conditions in the home;
- cite only valid deficiencies; and
- conduct surveys in accordance with federal requirements.

When HCFA identifies inadequate state performance, its first step is to impose one or more of several remedies against the state, with the objective of improving the state's performance. The most commonly used remedy has been to provide training for individual state surveyors or survey teams. A HCFA official indicated that other remedies are occasionally used but that training is viewed as the preferred approach. When remedies fail to improve state performance, HCFA can impose sanctions, which are intended to penalize a state agency for failing to improve performance. See table 7 for the remedies and sanctions now available to HCFA.

Table 7: Remedies and Sanctions Available to HCFA in Response to Poor State Agency Performance

Tool	Action
Remedies	— Provide training to survey teams
	— Provide technical assistance to the state with respect to scheduling surveys and following survey procedures
	— Require the state agency to implement improvements identified in the state's plan of correction
	— Assume responsibility for developing survey schedules for the state agency
	— Reduce the state's Medicaid funding for survey and certification activities
Sanctions	— Terminate the state's survey contract

Note: Remedies and sanctions are shown in the order they appear in HCFA documentation.

To reduce a state's survey and certification funding, HCFA must demonstrate that the state displays a pattern of failure to identify deficiencies in nursing homes.²⁷ To develop this information, HCFA compares the deficiencies it identifies through its surveys of nursing homes with those found by state surveyors. When HCFA determines that the quarterly disparity rate between the deficiencies it identified and those the state agency identified is greater than 20 percent in at least three of the

²⁷HCFA cannot reduce survey and certification funding to a state or terminate the state's contract based on a single instance of a state's failure to identify a situation that places the health or safety of a resident in immediate jeopardy.

last four quarters and the state fails to correct the disparity within the next two quarters, it may impose this sanction.

Currently, the only way HCFA can develop the specific quantitative evidence it needs to identify disparity rates is through comparative surveys. However, as previously discussed, the regions conduct too few such surveys to establish a pattern of inadequate state agency performance. For instance, 43 states and the District of Columbia will have only one or two comparative surveys per year. A HCFA official acknowledged that conducting so few comparative surveys is insufficient to establish a pattern of poor performance in any state. Therefore, this official told us, HCFA attempts to rely on observational surveys to obtain the needed quantitative evidence, but the official agreed that the present observational surveys are not designed to provide this information. As noted, 69 percent of the comparative surveys completed as of August 1999 identified deficiencies that were more serious than those found by state surveyors, but only in 1 percent of their observational surveys did the regions identify deficiencies that were more serious. This is largely because the goal of observational surveys is not to identify all deficiencies but rather to observe state survey performance. Thus, it does not appear that either the comparative or the observational surveys can provide the basis HCFA needs to use the sanction of reducing a state's Medicaid survey and certification funding for failing to properly identify deficiencies in nursing homes.

Terminating a contract with a state agency would require HCFA to find a replacement for the state surveyors. HCFA officials indicated to us that three alternatives exist: (1) use federal surveyors to conduct surveys in a state, (2) contract with another state agency in the same state, or (3) contract with a state agency from another state. According to HCFA and state survey agency officials, HCFA does not have a sufficient number of surveyors to conduct surveys in states that have a large number of nursing homes. Texas alone has 402 state surveyors, while HCFA has 122 surveyors nationwide. Six other states also have more surveyors than HCFA. Furthermore, even in smaller states, the use of federal surveyors for an extended period could become a problem because they would not be able to perform their normal monitoring duties and other responsibilities. With regard to the second alternative, the President of the Association of Health Facility Survey Agencies told us that contracting with another agency within the state is unrealistic given the negative atmosphere created between HCFA and the state if the state agency's contract has been terminated. The third alternative, contracting with another state, would be

feasible only if the contracting state had or could hire a sufficient number of surveyors to conduct surveys in both states.

Potential Effectiveness of Proposed Sanctions Is Doubtful

As part of its nursing home initiatives, HCFA established a task force in late 1998 to expand and clarify the definition of inadequate state survey performance and to suggest additional remedies and sanctions that HCFA could take against state agencies that perform poorly. HCFA indicated to us that new instructions should be issued sometime in the fall of 1999. However, on the basis of our review of the proposed changes, it is uncertain whether the additional sanctions HCFA is considering will be strong enough to compel a state agency to improve its performance.

Under its proposed guidelines, HCFA would add seven situations to its definition of inadequate state performance. These seven include situations in which a state agency has a pattern of failure to

- conduct surveys within required time frames;
- use proper enforcement actions against a nursing home;
- respond to complaints in accordance with requirements;
- enter nursing home deficiency data into HCFA's database timely and accurately;
- follow federal standards, protocols, forms, methods, procedures, policies, and systems specified in HCFA's instructions;
- ensure that nursing homes maintain specific resident information; and
- enter nursing home resident assessment data into federal data systems.

The proposed changes include a new remedy that would require HCFA to develop a plan of correction for the state to implement. In addition, two new sanctions are proposed to penalize a poorly performing state agency: (1) placing the state agency on notice that it is not in compliance with its Medicaid plan regarding nursing home survey performance and (2) requiring HCFA officials to meet with the state governor and other high-level state officials.

Although HCFA refers to the proposed two new actions as sanctions, they are not as severe as what is normally thought of as sanctions and may not be enough to compel a state to improve its performance. When we discussed placing the state agency on notice, we were told by a HCFA official that, under this sanction, HCFA expects the regions to work collaboratively with state agencies to comply with the requirements in their state Medicaid plan. The proposed sanction requiring HCFA officials to

meet with the governor or other state officials can raise problems to a higher level in state government and possibly secure greater state support to improve performance. Nevertheless, it is not clear what impact either of these sanctions would have on a state agency to effect the desired performance.

Conclusions

HCFA has recently demonstrated the desire and initiative to confront and respond to various quality problems facing the nation's nursing homes and their residents. Some of the methods HCFA currently uses and is developing, to ensure that state agencies develop effective survey programs capable of identifying survey deficiencies in nursing homes, can contribute useful information for assessing the overall effectiveness of its many nursing home quality improvement initiatives. However, the limited scope and rigor of its various state performance monitoring mechanisms, and the uneven application of the mechanisms across the regions, do not provide HCFA with a systematic, consistent means of assessing the sufficiency of state survey performance. Additionally, HCFA's approach to conducting federal monitoring surveys is not adequate to establish a pattern of inadequate state performance, which is needed before imposing any sanction. Specifically,

- the negligible use of comparative surveys, combined with delays in scheduling them to closely follow state surveys, does not provide HCFA with sufficient evidence to establish whether states are appropriately assessing nursing homes' compliance with federal standards.
- systems development problems for reporting results of observational surveys and delays in giving states written feedback have hindered HCFA's ability to effectively use survey results as a management tool.
- inconsistencies among HCFA regional offices in how they target their federal monitoring surveys within each state and select resident samples for comparative surveys further hamper HCFA's ability to ensure that these reviews effectively and equitably assess state survey performance.

Even if HCFA strengthens its oversight programs to be able to establish any pattern of unacceptable state survey performance, it has yet to develop effective alternatives for compelling the state to come into compliance with nursing home survey standards, short of cutting off federal funds. Being able to accurately and consistently assess state agency performance and hold states accountable for meeting HCFA standards is essential to the success of HCFA's recent initiatives to improve the quality of care for the nation's nursing home residents.

Recommendations

To ensure that states effectively meet federal standards for certifying nursing homes and to consistently implement the more stringent requirements of HCFA's recent initiatives, HCFA needs to strengthen its oversight of state survey agencies' activities. To accomplish this, we recommend that the Administrator of HCFA take the following actions:

1. Improve the scope and rigor of HCFA's oversight process by
 - increasing 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,
 - ensuring that comparative surveys are initiated closer to the time the state agency completes the home's annual standard survey,
 - requiring regions to provide more timely written feedback to the states after the completion of federal monitoring surveys, and
 - improving the data system for observational surveys so that it is an effective management tool for HCFA to properly assess the findings of observational surveys.
2. Improve the consistency in how HCFA holds state survey agencies accountable by standardizing procedures for selecting state surveys and conducting federal monitoring surveys, including
 - ensuring that the regions target surveys for review that will provide a comprehensive assessment of state surveyor performance, and
 - requiring 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 HCFA surveyors have determined that the state sample selection process was appropriate).
3. Further explore the feasibility of appropriate alternative remedies or sanctions for those states that prove unable or unwilling to meet HCFA's performance standards.

Agency Comments

In its comments on our draft report, HCFA noted that enhanced oversight of state programs is critical to improving the quality of care in nursing homes and generally agreed with our recommendations.

HCFA commented, and we agree, that a mix of comparative and observational surveys is a prudent approach to overseeing state survey

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agencies' performance. It did not agree to immediately increase the number of comparative surveys it requires the regions to undertake but stated that it is reviewing the issue of the appropriate balance between the two types of monitoring surveys. While we agree that a mix is beneficial, an adequate number of comparative surveys is critical to assess the performance of state agencies. Furthermore, these surveys can help improve the effectiveness of resources devoted to observational surveys by focusing more of them on areas of poorer performance. We believe that the results of the comparative surveys conducted in the past year indicate that these surveys have been more effective than observational surveys in identifying serious deficiencies affecting the health and safety of residents that state agencies' survey processes miss. While we agree that observational surveys can serve as an effective training tool for state surveyors, in our view, they do not provide an accurate representation of typical state surveyor performance because of the likelihood that state surveyors modify their performance when they are aware that they are being observed.

HCFA agreed that its comparative surveys should be initiated in closer proximity to the state agency's completion of the nursing home's annual standard survey. However, HCFA indicated that because it will focus its comparative surveys on deficiency-free homes in the future, it does not believe it would be realistic to start these surveys earlier than 2 weeks after the state has completed its survey because the results of the state survey are not often known for 2 weeks. But HCFA's decision to focus its comparative surveys on deficiency-free homes would exclude more than two-thirds of homes nationwide from this review. In addition to reconsidering the universe of nursing homes for which comparative surveys are conducted, we believe that HCFA can initiate a comparative survey more promptly, even if it means that HCFA does not know the results of the state's most recent survey before beginning its comparative survey. HCFA can still achieve its monitoring objective by choosing its sample on the basis of nursing homes' prior survey history and could improve results by having the two surveys more closely coincide. In fact, not having the results could eliminate any bias associated with having state survey results.

HCFA also agreed with the importance of ensuring national consistency in overseeing state survey agencies and establishing definitive and measurable performance standards to hold states accountable for survey performance. However, HCFA indicates that it will establish additional performance standards by the end of 1999. It will evaluate the use of these

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standards and its process for working with state agencies to improve their performance for about 18 months before determining whether other additional remedies or sanctions are needed. In our view, HCFA currently does not have an adequate array of effective remedies or sanctions at its disposal to ensure corrections, and it should more immediately consider expanding the available remedies and sanctions that can be applied to compel states to improve their performance.

HCFA's comments are included as appendix II.

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

Please contact me or Kathryn G. Allen, Associate Director, at (202) 512-7114 if you or your staffs have questions about this report. Jack Brennan and Mary Ann Curran prepared this report under the direction of John Dicken.



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

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Abbreviations

HCFA	Health Care Financing Administration
OBRA 87	Omnibus Budget Reconciliation Act of 1987
SAQIP	State Agency Quality Improvement Program

Appendix I

HCFA's Definitions of Severity of Deficiencies

HCFA's nursing home regulations established several categories of deficiencies that state survey agencies may find and record during their surveys. Each identified deficiency is placed into one of the 12 categories ranging from "A" to "L," depending on the extent of resident harm (severity) and the number of residents adversely affected (scope). The following table identifies the scope and severity HCFA has assigned to Medicare and Medicaid compliance deficiencies.

Table I.1: HCFA Scope and Severity Ratings for Nursing Home Deficiencies

Severity category	Scope of deficiency		
	Isolated	Pattern	Widespread
Actual or potential for death/serious injury (also referred to as immediate jeopardy)	J	K	L
Other actual harm	G	H	I
Potential for more than minimal harm	D	E	F
Potential for minimal harm (substantial compliance)	A	B	C

A home is considered to be in "substantial compliance" if any identified deficiencies are those in which the potential exists for only minimal harm to occur to residents (levels A, B, and C). Any nursing home with a deficiency categorized as D through L is considered to be not in compliance. "Potential for more than minimal harm" is a deficiency for which no actual harm has occurred to residents but that presents the potential for more than minimal harm to occur. "Other actual harm" includes deficiencies that cause actual harm to residents but do not immediately jeopardize their health or safety. "Immediate jeopardy," the most serious deficiency, includes situations that immediately jeopardize the health or safety of residents.

In addition to the four severity categories shown in the table, HCFA also uses a fifth deficiency category referred to as "substandard quality of care." Deficiencies in this category are those that affect nursing home residents in the areas of resident behavior and facility practices, quality of life, and quality of care, and that are in the F, H, I, J, K, or L categories in the table.

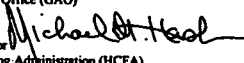
HCFA also classifies deficiencies by their scope or extent as follows: (1) isolated, defined as affecting a limited number of residents; (2) pattern,

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defined as affecting more than a limited number of residents; and
(3) widespread, defined as affecting all or almost all residents.

Appendix II

Comments From the Health Care Financing Administration

	DEPARTMENT OF HEALTH AND HUMAN SERVICES	Health Care Financing Administration
		Office Memorandum Washington, D.C. 20201
OCT 21 1992		
TO:	William J. Scanlon, Director Health Financing and Systems Issues General Accounting Office (GAO)	
FROM:	Michael M. Hash Deputy Administrator Health Care Financing Administration (HCFA) 	
SUBJECT:	General Accounting Office (GAO) Draft Report: <i>Nursing Homes: Enhanced HCFA Oversight of State Programs is Critical to Assure Quality Care</i>	
<p>I have attached the response of the Health Care Financing Administration to the GAO draft report entitled, <i>Nursing Homes: Enhanced HCFA Oversight of State Programs is Critical to Assure Quality Care</i>.</p>		
<p>This and earlier GAO reports recognize some of the improvement initiatives launched by HCFA, and help sharpen our focus on areas that need to be addressed. We agree with the GAO premise that enhanced HCFA oversight of state programs is critical to improving the quality of care in our nation's 17,000 nursing homes. Already, we are addressing many of the specific issues raised by the GAO report, and are studying additional measures we might employ.</p>		
<p>We appreciate the opportunity for the Health Care Financing Administration to comment on this report.</p>		

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Comments From the Health Care Financing
Administration

**Comments of the Health Care Financing Administration (HCFA)
On the General Accounting Office (GAO) Draft Report,
"Nursing Homes: Enhanced HCFA Oversight of State Programs
Is Critical To Assure Quality Care"**

Since July 1995, when the Clinton Administration began enforcing the nation's toughest-ever enforcement regulations for nursing homes, HCFA has been working aggressively to improve its enforcement procedures and practices that protect Americans who rely on nursing homes for care. In July 1998, reports by HCFA and GAO noted that conditions had improved but that more needed to be done. At that time, President Clinton announced a major new initiative to increase protections for vulnerable nursing home residents and crack down on problem providers.

This and earlier GAO reports recognize some of the improvement initiatives launched by HCFA and help sharpen our focus on areas that need to be addressed. We agree with the GAO premise that enhanced HCFA oversight of state programs is critical to improving the quality of care in our nation's 17,000 nursing homes. Already, we are addressing many of the specific issues raised by the GAO report and are studying additional measures we might employ.

We have increased our efforts on monitoring how states are implementing specific provisions, and determining where we need to take further action to ensure effective performance. For example, we have refined our Federal Oversight Support Survey (FOSS) protocols. We have stepped up efforts in HCFA's ten regional offices to improve consistency, cooperation and communication in the application of our guidelines across the country. We held national training conferences and satellite broadcasts for Regional surveyors on FOSS implementation. We have been developing performance standards for state survey agencies, definitions of inadequate performance, and a listing of sanctions and remedies available under current law and will finalize them within the next 90 days. In addition, we will redirect the State Agency Quality Improvement Program (SAQIP) to be a consistent national program directly tied to measurable and reportable performance standards.

New Survey Protocols

HCFA published the new nursing home initiative survey protocols on July 1, 1999, our target date. In addition to printed copies, HCFA made these new protocols available electronically to state agencies. They also are available on HCFA's website, www.hcfa.gov. These new standards addressed hydration, nutrition, and pressure sore

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quality indicators, among many other important changes. These protections are vital to guiding and training state surveyors and will assure a new level of consistency of surveying among the states.

Training on the Nursing Home Initiative

We have provided training and guidance to states on the President's nursing home initiative, including enforcement, use of quality indicators in the survey process, survey tasks in the areas of medication review, pressure sores, dehydration, weight loss, and abuse prevention.

Enhanced Oversight of Selected Facilities

HCFA has identified facilities in each state for more frequent inspection and intense monitoring, based on results of most recent annual inspections and any substantiated complaints during the previous two years. States have begun monitoring these facilities more frequently.

Monitoring Protocols for Tracking Nursing Homes Citing Financial Hardship

A top priority of HCFA is not only monitoring and regulating nursing homes but also assuring a high quality of care for their residents and protecting residents from the disruptions and dislocations that may accompany financial and other difficulties experienced by the facilities themselves. While some chains may choose to file for Chapter 11 bankruptcy protection, the filing does not diminish the facilities' responsibility to provide high quality care, and a good quality of life to residents in their nursing homes. In August 1999, HCFA issued three separate monitoring protocols to be used by states in visits to facilities citing financial troubles. These protections include an onsite monitoring protocol, a protocol for state ombudsmen, and a telephone monitoring protocol. The purpose of this monitoring is to uncover early warning signals that might indicate the possibility that a facility will fail to continue providing quality care to residents.

Contingency Plans for Protecting Beneficiaries in the Event of Nursing Home Chain Bankruptcy

HCFA has designed and implemented a management contingency plan that enables HCFA and affected states to respond quickly and effectively if the financial situation in a nursing home chain places resident health or safety at risk. In the event of such a development, the state government, through such agencies as emergency management, or survey or licensure, has the primary responsibility, but the federal government will provide available resources and support to the states in protecting residents. HCFA's plan spells out the responsibilities of the state and federal governments. Ongoing activities at

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HCFA include biweekly meetings with the Deputy Administrator to develop strategies and monitor progress as well as regular consultation with HCFA regional offices, the states, the Department of Justice, the Office of the Inspector General, Office of General Counsel, the Administration on Aging, and others.

Abuse Intervention Campaign

A new abuse intervention campaign is now active in 10 pilot states. This program places posters and other printed messages in nursing homes to inform residents and their families of the signs of abuse and tells them how to report it. The program is being tested in Massachusetts, New Jersey, West Virginia, Georgia, Wisconsin, Louisiana, Missouri, Colorado, Arizona, and Idaho. HCFA will use feedback to expand this information campaign.

Enhanced Enforcement

HCFA has been vigorous in encouraging states to apply appropriate sanctions for noncompliance. HCFA has taken a variety of other steps to strengthen enforcement. Closer scrutiny and immediate sanctions for states will help prevent "yo-yo" compliance, in which problems are fixed temporarily, only to be cited again in subsequent surveys. HCFA has directed states to stagger surveys and conduct a set amount on weekends, early mornings and evenings. States are required to revisit facilities in person to confirm that violations have been corrected before lifting sanctions. HCFA has developed a significant new compliance tool and issued regulations that enable states to impose civil money penalties for each serious incident. HCFA has also been working with the Department of Justice to improve referral for potential prosecution of egregious cases where residents have been harmed.

The following outlines in more specific detail the HCFA responses to the GAO recommendations:

GAO Recommendation -1

- (1) Improve the scope and rigor of HCFA's oversight process by:
 - (a) increasing the proportion of federal monitoring surveys conducted as comparative surveys to ensure that a sufficient number of these surveys are completed in each state to assess whether the state appropriately identifies serious deficiencies.

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HCFA Response

The report promotes the value of using comparative surveys to identify issues related to state performance. However, other evidence emphasizes the merits of other approaches, such as observational surveys. The report does not provide sufficient information to determine the relative merits between the observational (FOSS) and the comparative surveys. In fact, a recent HHS Office of Inspector General report on hospitals recommended that HCFA de-emphasize and even phase out validation (comparative) surveys and consider incorporating observational surveys into its oversight activities. We believe that the most prudent approach at this time is one that includes both comparatives and FOSS surveys. In addition, we need to assure that there are enough comparative surveys in order to study the relative merits of each. We are reviewing this issue to determine the appropriate balance between the two and the budget implications of implementing any changes.

The FOSS provides for a comprehensive review of state survey activity. It enables HCFA, through its regional offices, to evaluate the State surveyors' investigation, data analysis and preliminary deficiency findings during the standard recertification, complaint, initial or revisit surveys. It also mandates a review of the deficiency report after the survey is completed, the management review and after any informal dispute resolution. The FOSS review protocol is a measurement tool to assure consistency in the regional assessment of a broad range of state agency functions. These include:

- documentation of deficiency citations
- quality assurance review by State Agency supervisors
- timeliness of the deficiency findings report to the facility
- appropriateness of the scope and severity determinations
- informal dispute resolution decisions
- surveyor skills (investigation, data analysis, decision making, professionalism, interviewing techniques, and general communication ability)
- survey results
- adherence to federal survey policies and protocols

The comparative survey allows the regional office to identify whether the chosen facility is in compliance with the federal regulation and compare any deficiencies to the State Agency's findings. It does not provide a full assessment of how and why the state agency failed to identify serious deficiencies on any given survey.

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GAO Recommendation -1

- (1b) Ensuring that comparative surveys are initiated in closer proximity to the state agencies' completion of the home's annual standard survey.

HCEA Response

We agree and have already taken action regarding the length of time that is allowed to lapse between the state recertification survey and the comparative survey. While the statutory requirements allow 60 days between the state recertification survey and the federal comparative survey, the current average is 30 days.

Before the end of the year, HCFA will implement a revised comparative survey procedure including new time frames for initiating the comparative survey. This procedure directs staff in regional offices to start comparative surveys from two to four weeks after the state has completed its annual survey. Some regions are currently starting many comparative surveys within this two to four week time frame.

We do not believe that it would be realistic, at this time, to mandate that all comparative surveys start earlier than within 2 weeks after the state has completed its onsite review. Several logistical and operational limitations make it difficult to initiate comparative surveys in such a short time frame. Since a focus on our comparative surveys over the next year will be deficiency free facilities for those with deficiencies with a scope/severity of "C" or less, the comparative survey site cannot be selected until after the survey report has been completed. For example, states are allowed 10 days to complete deficiency reports and notify facilities. HCFA, then, would not receive the information necessary for selecting facilities for comparative surveys until after 10 days. We will continue to analyze the time frames that are being applied by regions, and work on methods for further reducing them.

GAO Recommendation -1

- (1c). Requiring regions to provide more timely written feedback to the states after the completion of federal monitoring surveys

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HCFA Response

We agree with the recommendation that the regions provide more timely feedback to the state agency supervisors after the completion of federal monitoring surveys. In an effort to ensure that the feedback of state management is consistent across the nation, HCFA is developing a national standard reporting form and time frames for feedback and will complete its work by November 30, 1999. This process will then be implemented nationally.

In August 1999, the Director of the Center of Medicaid and State Operation directed all regions to report to the state agency Director at least monthly on survey process errors, omissions and significant findings resulting from Federal Monitoring Surveys. Even though some regional offices have consistently been innovative and diligent in feeding back performance information, this direction defines minimum expectations for national feedback.

GAO Recommendation -1

- (1d). Improving the data system for observational surveys to be an effective management tool for HCFA to properly assess the findings of observational surveys.

HCFA Response

Because of the limitations of the present data system, HCFA expects to implement a new system as soon as November 1999. The current system was developed on an emergency basis as an interim system to meet minimum needs of the regions and central office. Under the current interim system, regions have available hard copy and database files, which can be analyzed. HCFA is now in the final phases of developing an updated system. The application is in Microsoft ACCESS and includes powerful, easy to use query and report generating capabilities that can be utilized by end users.

GAO Recommendation -2

- (2) Improve the consistency in how HCFA holds state survey agencies accountable by standardizing procedures for selecting and conducting federal monitoring surveys, including:

(2a-b) Assuring that the regions target surveys for review to provide a more

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comprehensive assessment of state surveyor performance, and requiring federal surveyors to include many of the same residents in their comparative survey sample as those included in the state's sample (where it has been determined that the state sample selection process was appropriate).

HCFA Response

We are committed to ensuring maximum consistency in oversight of survey agencies. We have initiated several steps toward this goal over the last year including ongoing efforts to improve the design and implementation of the FOSS and comparative surveys.

We agree with GAO that the core elements required in every FOSS survey be expanded. Effective August 1999, regional office staff was informed and trained to include several additional "tasks," including off-site preparation and additional survey analyses. It should be noted, however, even over the past year most regions were observing more than the required tasks. In 547 FOSS surveys, at least 75.3% of the tasks were observed.

We also agree that comparative surveys should include a portion of the state agency sample of residents. HCFA developed a revised sampling procedure that requires the region to include all state agency sampled residents that were chosen for comprehensive review. We expect this procedure to be implemented before the end of the year.

In an effort to improve consistency, HCFA issued clarifications of FOSS to ensure more consistent interpretations. For example, HCFA clarified that federal surveyors should provide guidance to state surveyors. Furthermore, we continue to have training for federal surveyors on the appropriate application of the FOSS process. In fact, we recently conducted face to face training for all federal surveyors.

HCFA will further review survey selection procedures and issue any clarifications needed to assure a standard selection process nationwide. This is consistent with our proposed selection process for oversight of hospital surveys and our commitment to improving national consistency. We will take other appropriate steps to improve national consistency as quickly as possible.

GAO Recommendation 3:

- (3) Further explore the feasibility of appropriate, alternative remedies or sanctions for those states that prove unable or unwilling to meet HCFA's

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performance standards.

HCEA Response

We agree with the report's description of the statutory and operational parameters that characterize HCFA's ability to ensure state agency accountability for survey performance. The most critical factor for assuring state accountability is to establish definitive and measurable standards.

As we have indicated, we will be establishing definitive and measurable performance standards, by the end of 1999, which will serve as the basis for holding states accountable. The standards will include performance areas such as timeliness of surveys, documentation of deficiencies, expenditure of funds and adherence to survey policies and protocols. Each performance standard will have a threshold criterion, and review instructions for regional staff to conduct standardized evaluations of State performance. The state agencies have been consulted during development of the standards and the process.

Once these performance standards are defined and states have a clear understanding of what is expected, HCFA will further explore alternative options for appropriately sanctioning or rewarding states based on their performance in protecting nursing home residents. Where states fail to meet the standards, HCFA will use the appropriate remedy or sanction to improve performance. Based on past experience, we expect the process of working with the states on corrective actions will lead to improved performance. We will evaluate the effectiveness of this process over the next 18 months to determine if additional remedies or sanctions should be developed. In addition, we intend to redirect SAQIP (State Agency Quality Improvement Program) so that it is a consistent national program directly tied to measurable and reportable performance standards.

Related GAO Products

Nursing Home Oversight: Industry Examples Do Not Demonstrate That Regulatory Actions Were Unreasonable (GAO/HEHS-99-164R, Aug. 13, 1999).

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

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

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

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

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

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

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The CHAIRMAN. Mr. White.

**STATEMENT OF STEVE WHITE, RALEIGH, NORTH CAROLINA,
ON BEHALF OF THE ASSOCIATION OF HEALTH FACILITY
SURVEY AGENCIES**

Mr. WHITE. Thank you, Mr. Chairman, for providing this opportunity for the Association of Health Facility Survey Agencies to participate in this hearing.

I would like to take a couple of minutes to summarize AHFSA's written testimony concerning inconsistencies in Federal oversight and HCFA's plans to impose sanctions on States.

We believe that oversight and monitoring the States is important to ensure uniform application of Federal policy in the Medicare and Medicaid programs. It is important that it be based on valid, objective, and reliable data that are applied consistently from region to region.

Our concerns cover three broad areas. These areas are: workload priorities with limited resources; the differences in administration of the program from region to region; and the Federal monitoring system.

First and foremost, it is critical that HCFA understand why there are differences among States and the many factors that lead to these differences. After this is understood, an oversight system must be developed that is objective, reliable, and verifiable to assess State performance and compare it with other States.

Our greatest concern involves the subjective judgments made by Federal surveyors in comparison surveys. HCFA has spent many years and millions of dollars developing a system of quality indicators for nursing homes to be able to compare one nursing home with another. A similar effort should be undertaken to evaluate and compare States nationally.

A revised States Operations Manual transmittal on State performance standards and sanctions is soon to be released. The parts of the policy related to survey activity rely heavily on Federal surveyor judgment of State surveyors' performance and lend themselves to subjectivity.

States are concerned about a GAO recommendation that HCFA return to doing primarily comparison surveys. Historically, this process has proven to be flawed, primarily because there are too many factors that influence differences between surveys when they are done at different times, using different resident samples.

Second, there are vast differences in how the survey and certification program is administered from region to region. There are marked difference in the philosophy toward the States from one regional office to another that will certainly affect how oversight and sanctions are administered.

For example, the Kansas City regional office has a reputation for being collaborative in its relationship with the States in its region. Unfortunately, other States report that their regional office communicates poorly with them and that there exists a more adversarial relationship.

Nursing home enforcement is one example of an area where there are significant variations in how the program is administered. One example is the termination of nursing homes with low-

level deficiencies from the Medicaid and Medicare programs. Current regulations require that if a nursing home does not come into substantial compliance within 6 months, it must be terminated from the program. Regional offices and States have found many innovative ways to avoid terminating nursing homes with less serious deficiencies because they believe the residents are the ones ultimately being harmed. Reported ways include ending one survey cycle and starting another, extending termination dates, and requiring States to do multiple follow-up visits. Other ways include allowing the facility to fix the problem while the surveyors are on-site, or changing the scope and severity of the deficiency.

The third area is that of resources. Although we appreciate HCFA's attempt to obtain additional funds from the States, individual States and AHFSA have made it very clear that until funds become available, positions set up and staff hired and trained, States do not presently have the resources to meet all of HCFA's mandates. This is of critical importance because the draft SOM issuance sets out performance standards that are not being met at the present time.

New performance standards relate to the 12-month survey average and complaints. Very few States will be able to meet both a 12-month survey average and investigate the ever-increasing number of complaints in a reasonable timeframe. For example, nursing home complaints have doubled in my home State of North Carolina in the last year.

In the face of continuing additional workload mandates, States are faced with making individual decisions as to what work to do and what work to leave undone. Sanctioning States for not meeting performance standards for which HCFA is not providing the resources is unreasonable.

In closing, I would like to say that until HCFA provides adequate resources, clear guidance, and uniform application of its policies, it is simply premature to issue a procedure which so clearly threatens the States with sanctions for shortcomings often beyond their control.

As I have stated before, the States do not object to objective and legitimate criticism if we do not perform. AHFSA pledges to work with HCFA in a cooperative fashion to help develop a system that works.

Thank you, Mr. Chairman, for providing us this opportunity.

The CHAIRMAN. Thank you very much.

[The prepared statement of Mr. White follows.]



Testimony of

Steve White, Immediate Past President

On behalf of

The Association of Health Facility Survey Agencies

Before the Senate Committee on Aging

November 4, 1999

Thank you for providing this opportunity for the Association of Health Facility Survey Agencies (AHFSA) to participate in this hearing. I am Steve White, Immediate Past President of the Association. AHFSA represents the leaders of state survey agencies across the country. We were established in 1970 to provide a forum for state directors to share information and to work with HCFA, provider organizations, advocates and others to promote quality health care in a variety of health care settings. We continue to believe that surveillance and enforcement activities are the most important and effective means by which the federal and state governments can assure quality health care for beneficiaries. Over the last three

years and especially since the unveiling of the President's Initiatives for Nursing Homes the relationship between HCFA and the states has changed. HCFA has moved from a model of total quality management, emphasizing partnership and collaboration with the states in developing improvement strategies, to a model where policies are being developed centrally and with some exceptions with little input from the states. Rhetoric which directs the blame for poor nursing home care to the states has been unfortunate and unfair. This situation is best illustrated by the announcement of the President's Initiatives and complaint initiative. These were centrally-developed HCFA initiatives finalized and announced without prior state input or knowledge and without first considering and securing the resources necessary to implement them. In prior testimony to this Committee, the Association provided summary information demonstrating the continued untenable position the states are facing in trying to meet ever-increasing workload expectations in the absence of commensurate funding increases over the last decade. The states are simply not able to carry out all of HCFA's expectations within existing resources. Although HCFA has been made acutely aware of this fact and has worked to secure additional funding that may be available in the future, they have been unable to adjust national program priorities and have continued to issue additional directives mandating new program activities. Another example is a directive to monitor, at least monthly, facilities in chains that have

filed for bankruptcy protection. In some states this is a significant additional workload. It is particularly disturbing to the states therefore, that HCFA, responding to the very real need to strengthen its oversight role, is now undertaking the development of a state oversight and sanctioning process that establishes program standards which ignore these very real and conflicting resource and program priority issues which will prevent many states from meeting these standards. A revised State Operations Manual (SOM) issuance on state performance standards and sanctions is soon to be released. We know that even as HCFA is working on these state performance measures that lack of resources prevents many states from meeting them. We fully agree that HCFA has every right to get what they pay for in their contractual arrangement with the states. We also do not disagree that there should be oversight. Oversight is important and necessary to insure consistency and direction. We do believe however that any sanctions levied against states should be fair and consistently applied from region to region. They should be based upon consistent objective and valid data that is applied uniformly from region to region. HCFA has spent many years and many millions of dollars developing quality indicators for nursing homes that can be used to compare one nursing home with another. These indicators have been developed by professional researchers, validated and tested for reliability. No system presently exists that can identify differences between states and make valid

comparisons. There are many issues related to this new policy. This policy can be used to penalize states for simply disagreeing with HCFA on the level or scope of a problem, often a professional disagreement between federal and state surveyors. One section allows the regional offices to recover money from the states if there is disagreement over whether conditions in a nursing home constitute immediate jeopardy for the residents. The guidelines for immediate jeopardy are vague at best and two professionals can disagree over whether food temperatures, restraints, hot water temperatures or many other things constitute immediate jeopardy. If the state determines that immediate jeopardy exists or does not exist and the regional office disagrees then sanctions can be levied. Another section allows for sanctions against a state if there is a 20% disagreement in deficiencies cited between the regional office and a state regarding survey results over time. The assumption that the regional office is always correct is inaccurate. States have highly qualified and competent survey staff who are at least as qualified as regional office staff. In most cases with the number of surveys they do each year state survey staff are more experienced. State staff have always had the responsibility to cite deficient practices that are sustainable and defensible in an informal dispute resolution, administrative hearing process and court of law. Federal surveyors are not subject to this same legitimate challenge on a routine basis. Another issue relates to a state's ability to challenge differences between the regional office and the state.

HCFA has allowed a mechanism to contest findings only when sanctions are imposed. With a 20% disagreement threshold all surveys could lead to sanctions at a later date based upon cumulative survey data. AHFSA has repeatedly requested that states be notified in writing immediately of any problems that might lead to later sanctions in order to correct weaknesses in the survey process or challenge the findings. The new SOM issuance also includes performance standards that states must meet. At present HCFA is not providing the resources to meet all of these standards. Two performance standards are that states must perform all surveys within fifteen months and maintain a twelve month survey average and that states must perform complaint visits according to HCFA policy. HCFA knows quite well that the 12 month average is slipping nationally. While the states support the complaint policy and believe in many cases that complaints should be prioritized ahead of standard surveys once again many states do not have the resources to meet these time frames. Few states in reality have the resources to meet both of these performance criteria and those that do often have significant state resources that are supplementing their activities. HCFA has been told repeatedly by AHFSA that resources are not available to perform all of the work HCFA is requiring of the states but has been unable to get guidance as to how the work should be prioritized. To include performance standards that HCFA is not providing the resources to meet and then threatening to sanction the states for not meeting them is not

reasonable. An important and compounding factor in the states' concern about the proposed oversight/sanction process is the historical and ongoing pattern of inconsistency in how HCFA's regulations and guidelines are interpreted from region to region. I want to take a few minutes and note some of the differences. The first and most obvious difference is the difference in philosophy from regional office to regional office and even within consortiums. For example the Kansas City regional office has a reputation of being responsive and supportive. They work towards a relationship that includes collaboration and partnership with the states in their region. They provide feedback after federal surveys and request input from the states on how to solve difficult issues. Other regional offices are on the other end of the continuum. They have provided little ongoing feedback after federal monitoring surveys and have a more regulatory mentality towards the states. Regional offices are also inconsistent in the way enforcement is handled. One example is the termination of nursing homes from the medicaid and medicare program with low level deficiencies. Advocates, providers and most states have come to believe that terminating a nursing home with isolated deficiencies that constitute no actual harm to the resident is not the best solution. Current regulations require that if a nursing home does not come into substantial compliance within 6 months then it must be terminated from the medicare and medicaid program. Regional offices and states in these situations have found many

innovative ways to avoid terminating nursing homes with only less serious deficiencies because they do not believe the punishment fits the crime. Reported ways include regional offices ending one survey cycle and starting another one, extending the termination date, or requiring the states to do multiple follow up visits until the facility is finally back in compliance. Other ways include allowing the facility to fix the problem while the surveyors are still on site, cite the deficiency and note in the report that it has been fixed on site or simply change the scope and severity of the deficiency. States can bring the facility back into compliance by not citing additional deficiencies or recommend the termination of the facility. A similar example is the case where a nursing home has corrected all deficiencies that were cited on the original survey by the time of the follow up visit but have other deficiencies. Some regional offices and even states within regions start a new enforcement cycle while others continue towards termination. Some regional offices are very responsive in processing enforcement cases while others do not meet timeframes. There are also marked differences in the way state budgets are handled. The allocation process of money to the states is both confusing and inequitable. Factors such as the amount of state share, indirect cost rates and other factors lead to wide variations in the amount of money different states have available to them. Some regional offices have full time budget positions that scrutinize and micromanage the states budget process and expenditures

throughout the year. Others simply allocate the money to the states and monitor their expenditures through quarterly reports, leaving most of the accountability up to the states. Regional offices give the states widely varying latitude in administering their programs. For example the San Francisco regional office has allowed states and has sometimes participated in trying new and innovative approaches often beneficial to the states while some of the other regional offices are very rigid and don't allow states to deviate from HCFA policies. There are also differences from regional office to regional office on such things as defining what a home health branch office and sub unit are, how bed changes are handled as well as many other things. The federal monitoring survey process is an area where there is a great deal of concern by the states. Even though HCFA central office has required the regional offices to provide clear, concise and timely feedback to the states the variation in what states are receiving is remarkable. Some regional offices like Kansas City are assuring that states receive clear concise written feedback after every survey (as it should be) while other regional offices are providing little feedback at all. Those states that are not getting appropriate feedback cannot correct problems that exist if they are not aware of what the problems are. Although we have not seen the GAO report we have heard that there is a recommendation that HCFA return to doing primarily comparison surveys as the monitoring mechanism of choice. Most states would be opposed to this

approach because historically it has not worked well. There are too many factors that influence differences between surveys when they are done at different times. Factors include different resident samples, change in conditions in nursing homes, and different survey team compositions staying different lengths of time and emphasizing different parts of the process. If the intent of the monitoring process is to evaluate state surveyor competency and ability to follow a standardized survey process, then concurrent monitoring represents a more rational approach. Most states have come to believe that limited resources in the survey process should be redirected to where the problems exist. Ideally resources would be available to survey all nursing homes not only on a 12 month average but more often, investigate all complaints within 10 days, monitor financially troubled facilities and do quality follow ups (as many as necessary). The current reality however is limited resources. With the availability of quality indicator data, we believe the process can be reevaluated within statutory parameters and through creative HCFA policy initiatives allow the flexibility to put limited resources where problems exist. This will result in less predictability in the survey process, improved responsiveness to complaints and our ultimate customer the resident and residents' family members. We would like to work with HCFA and other interested parties to develop workable policy initiatives. In closing, I would like to say that, until HCFA provides adequate resources, clear guidance and uniform application of its

policies across regions, it is simply premature to issue a procedure which so clearly threatens the states with sanctions for shortcomings often beyond their control. As I have stated before, the states do not object to objective and legitimate criticism if we do not perform and AHFSA pledges to work with HCFA in a cooperative fashion to help develop a system that works. Thank you for the opportunity to testify today on this important issue.

The CHAIRMAN. Mr. Hash.

**STATEMENT OF MICHAEL HASH, DEPUTY ADMINISTRATOR,
HEALTH CARE FINANCING ADMINISTRATION, U.S. DEPARTMENT
OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC**

Mr. HASH. Chairman Grassley, Senator Breaux and other members of the committee, we want to thank you for inviting us to discuss our efforts to improve oversight and quality of care for America's nursing home residents.

We have been aggressively working to improve protections for nursing home residents since 1995 when the Clinton administration began enforcing the toughest nursing home regulations ever. This effort, along with the committee's support and the GAO's continued involvement, has helped to sharpen our focus.

We agree that enhanced oversight of State surveyors is critical for improving the effectiveness of the survey process and quality of care. We are already addressing many of the issues raised by the GAO.

We are also working to increase consistency, cooperation, and communication among our regional offices. We continue to refine our protocol for Federal oversight of State surveyors. We have held training conferences and satellite broadcasts for Federal surveyors. We are developing measurable and reportable performance standards for State survey agencies, including definitions of inadequate performance and a listing of sanctions and remedies available under current law, which we will complete within the next 90 days. We will redirect the State Agency Quality Improvement Program, or SAQIP, to be a consistent national program directly tied to these measurable performance standards.

While we know we have much left to do, we are making solid progress, and I think we are beginning to see evidence that our Nursing Home Initiative is having an impact. We have been greatly aided in our efforts by this committee and particularly by your leadership, Mr. Chairman, in helping us secure the needed funding to carry this forward.

We agree with the GAO that comparative surveys have an important role in our oversight efforts. They do find more deficiencies that are missed by State surveyors. Observational surveys, however, also play an important role in enabling us to directly observe and evaluate State surveyors' work and assess how and why they may have failed to identify problems.

We believe the most prudent approach, at this point, is one that includes both types of surveys, and we are closely reviewing this to determine the appropriate balance. We are also working to improve our own Federal responsibilities. We are shortening the time between State surveys and comparative surveys. The law now allows up to 60 days, but the current average of comparative surveys is 30 days. By the end of the year, we will direct our staff to initiate all comparative surveys within 2 to 4 weeks of the State surveys, and we are directing the Federal survey teams to focus on facilities found to be deficiency-free on State agency surveys.

We are also working to provide State surveyors with faster feedback from our observational surveys and have directed all of our regional offices to report to State survey agency directors on a

monthly basis any errors, omissions, or findings that are identified. By the end of this month, we expect to have a national standard reporting form as well as standard timeframes for providing feedback to State surveyors and State survey agency heads.

We are working diligently to develop a better data system for reporting and tracking the findings of these oversight surveys.

We are also reviewing procedures and expanding the scope of our observational surveys. We have made clear to our State and Federal surveyors that the Federal surveyors can and should provide guidance to State surveyors during this type of survey. And we have training underway to help our surveyors improve the quality of their oversight efforts.

We are continuing to review procedures for selecting which State surveys to observe to ensure that we have a standard selection process nationwide. We also are taking concrete steps to improve our regional offices' oversight. We have developed performance measures for our regions to use more consistently in their evaluation of State agency performance. We have developed a cross-regional survey team made up of regional office employees who will survey facilities outside their own regions, and we have undertaken a nationwide information-sharing effort to ensure that the solutions to particular problems occurring in one region are shared with all regions.

In conclusion, Mr. Chairman, I want to stress our serious concern about the adverse impact on nursing home residents that would result from the FY 2000 appropriation bill now under consideration. The decrease from our request would force us to cancel the expansion of all Nursing Home Initiative activities planned for FY 2000 and further weaken our ability to sustain an effective oversight effort. We need your help in continuing to move forward.

Mr. Chairman, I think we are making solid progress in improving the quality of care and oversight in America's nursing homes. We agree that consistency in this effort is essential, and we are committed to consistency among our regional offices, clear guidance, better data systems, and measurable performance standards nationwide.

I want to thank you again for holding this hearing, and I would be happy to answer any questions that you or other members of the committee may have.

[The prepared statement of Mr. Hash follows:]

Testimony of
MICHAEL HASH
DEPUTY ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION

Before the
SENATE SPECIAL COMMITTEE ON AGING
on
IMPROVING OVERSIGHT AND QUALITY
OF
NURSING HOME CARE

November 4, 1999



Testimony of
**MICHAEL HASH, DEPUTY ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION**
on
IMPROVING OVERSIGHT AND QUALITY OF NURSING HOME CARE
before the
SENATE SPECIAL COMMITTEE ON AGING
November 4, 1999

Chairman Grassley, Senator Breaux, distinguished Committee members, thank you for inviting me to discuss our efforts to improve oversight and quality of care for America's 1.6 million nursing home residents. I would also like to thank the General Accounting Office (GAO) for its continued involvement and evaluation, and for its recognition of our progress and commitment.

We have been aggressively working to improve protections for vulnerable nursing home residents since 1995, when the Clinton Administration began enforcing the toughest nursing home regulations ever. This and earlier GAO reports help to sharpen our focus in these efforts. We agree with the GAO that enhanced oversight of State surveyors is critical for improving the quality of care in our nation's 17,000 nursing homes. And we are already addressing many of the specific issues raised in this GAO report.

- We are working to increase consistency, cooperation, and communication among our regional offices.
- We continue to refine protocols for federal oversight of State surveyors.
- We have held training conferences and satellite broadcasts for federal surveyors.
- We are developing measurable and reportable performance standards for State survey agencies, including definitions of inadequate performance and a listing of sanctions and remedies available under current law, which we will complete within 90 days.
- And we will redirect the State Agency Quality Improvement Program to be a consistent national program directly tied to these measurable performance standards.

While we have much left to do, we are beginning to see evidence that our nursing home initiative is having an impact. The number of violations identified per survey increased from 4.8 in the year preceding the initiative to 5.5 in the year since it began. The number of violations with actual harm or immediate jeopardy to resident health and safety identified per survey increased from 0.65 to 0.73. And the number of facilities terminated for violation of health and safety standards increased from 39 to 45.

We have been greatly aided in our efforts to improve protections for nursing home residents by the assistance of this Committee, and particularly by your leadership, Chairman Grassley, in helping us secure needed funding. We know you appreciate the challenge of implementing the 30 distinct, often complicated, and interrelated provisions we are working to implement. The tasks require dozens of agencies and thousands of individuals across the country to literally and substantially change the way they conduct their business. We are committed to taking all these, and any additional, actions that will help build upon our efforts. By continuing to work with you, the GAO, States, advocates and providers, we will together put an end to the intolerable situations that have caused this most vulnerable population to needlessly suffer.

I must stress, however, our great concern about the adverse impact on nursing home residents that would result from budget proposals now under consideration. A \$15 million decrease from our current survey and certification budget would force us to cancel the expansion of all nursing home initiative activities planned for 2000. A \$4.6 million decrease in our administrative budget would further weaken our ability to conduct oversight and thwart efforts to ensure continued quality care for residents in nursing homes facing financial difficulties. A \$9.5 million decrease in the General Departmental Management account would eliminate all resources needed to handle increased litigation and appeals resulting from the imposition of more nursing home sanctions. Additional across-the-board funding cuts would further reverse the progress we have made and endanger vulnerable nursing home residents.

BACKGROUND

Protecting nursing home residents is a priority for this Administration and our Agency. We are committed to working with States, which have the primary responsibility for conducting inspections and protecting resident safety. Through the Medicare and Medicaid programs, the federal government provides funding to the States to conduct on-site inspections of nursing homes participating in Medicare and Medicaid and to recommend sanctions against those homes that violate health and safety rules.

In 1995, the Clinton Administration began enforcing the nation's toughest-ever nursing home regulations. These regulations brought about measurable improvement, as documented in our 1998 Report to Congress. However, that report and investigations by the GAO made clear that more needed to be done. President Clinton therefore announced a major new initiative to increase protections for vulnerable nursing home residents and to crack down on problem providers.

NURSING HOME INITIATIVE PROGRESS

We have made substantial progress in implementing many facets of this initiative.

- We published new protocols for conducting nursing home surveys which specifically address areas where there have been significant problems, including hydration, nutrition, and pressure sores. These protocols are vital to guiding and training State surveyors and will assure a new level of consistency of surveying among the States.
- We provided training and guidance to States on the President's nursing home initiative, including enforcement, use of quality indicators in the survey process, survey tasks in the areas of medication review, pressure sores, dehydration, weight loss, and abuse prevention.
- We required States to evaluate all complaints alleging actual harm within 10 days. Last month we issued detailed guidance on how to evaluate and prioritize complaints. Key staff from each of our regional offices will be meeting with State survey agencies to discuss these guidelines and facilitate sharing of best practices in complaint management.
- We identified facilities in each State for more frequent inspection and intense

monitoring, based on results of most recent annual inspections and any substantiated complaints during the previous two years. States have begun monitoring these facilities more frequently.

- We vigorously encouraged States to impose sanctions on facilities that do not comply with health and safety regulations.
- We urged States to impose especially close scrutiny and immediate sanctions for facilities that demonstrate “yo-yo” compliance by fixing problems temporarily, only to be cited again in subsequent surveys.
- We instructed States to stagger surveys and conduct a set amount on weekends, early mornings, and evenings.
- We required States to revisit facilities in person to confirm that violations have been corrected before lifting sanctions.
- We issued regulations that enable States to impose civil money penalties for each serious incident.
- We have been working with the Department of Justice to improve referral for potential prosecution of egregious cases in which residents have been harmed.
- And we are testing an abuse intervention campaign in 10 States, with posters and other printed messages in nursing homes to inform residents and families about the signs of abuse and how to report it.

We also are taking steps to protect residents in facilities that may be experiencing financial or other difficulties from any disruptions or dislocations. We have made clear that filing for Chapter 11 bankruptcy does not diminish a facility’s responsibility to provide residents with high quality care and a good quality of life. We issued monitoring protocols designed to help State surveyors and ombudsmen uncover early warning signals that might indicate the possibility that a facility in financial difficulty will fail to continue providing quality care to residents. And we developed a management contingency plan spelling out responsibilities of State and federal

governments so we can respond quickly and effectively if a facility's financial situation places resident health or safety at risk.

To improve consistency in how these efforts are implemented across the country, we have established a workgroup that includes key central and regional office staff. This workgroup is promoting clear and consistent communication among all involved staff. And it is specifically addressing areas where inconsistencies have been identified.

COMPARATIVE vs. OBSERVATIONAL SURVEYS

We agree with the GAO that comparative surveys, in which federal surveyors conduct a completely separate review and compare results to those of a State survey of a given facility, have an important role in our oversight efforts. Comparative surveys do find more deficiencies missed by State surveyors.

Observational surveys, on the other hand, in which federal surveyors accompany State surveys to review their performance, also have an important role. They enable us to directly evaluate State surveyors' work and assess how and why they may have failed to identify problems. Our protocol for oversight surveys provides a measurement tool to assure consistent assessment of a broad range of results and functions, including:

- surveyor skill at investigation, data analysis, decision making, professionalism, interviewing techniques, and general communication ability;
- whether surveyors appropriately determine the scope and severity of problems;
- whether surveyors properly documented problems;
- how promptly problems are reported to the facility being surveyed;
- how well States use informal dispute resolution;
- quality assurance review by surveyors' supervisors; and
- adherence to federal survey policies and protocols.

We believe that the most prudent approach at this time is one that includes both comparative and observational surveys. We are reviewing this issue to determine the appropriate balance between the two and the budget implications of any changes.

In the meantime, we are shortening the time between State surveys and comparative surveys. The law allows up to 60 days, but the current average now is 30 days. By the end of the year, we will direct our staff to initiate all comparative surveys within two to four weeks of State surveys. We also are directing Federal survey teams to focus comparative surveys on facilities that were found to be deficiency free on the State survey. (There are several reasons why we need to wait two weeks to start a comparative survey. For example, State surveyors have 10 days to notify a facility of any identified deficiencies, and these notifications are among the things evaluated in a comparative survey.)

We are working to provide State surveyors with faster feedback on findings from our observational surveys. In August, we directed all our regional offices to report to State survey agency directors at least once a month on survey process errors, omissions, and findings identified in observational surveys. And we expect to complete development of a national standard reporting form, as well as standard time frames, for providing feedback to State surveyors by the end of this month.

We also are working to ensure that our surveyors interview some of the same residents interviewed by State surveyors. This is being done as we revise the "sampling" procedure for choosing which residents are included in the federal sample. We expect to implement this revised sampling procedure by the end of the year.

For observational surveys, we are working diligently to develop a better data system for reporting and tracking findings. We expect to complete it yet this month, and have scheduled training on its use for our staff in December. The current system was developed on an emergency basis as an interim system to meet minimum needs. The improved system will include powerful and easy-to-use query and report-generating functions.

We also are reviewing procedures and expanding the scope of our oversight surveys in an effort to be more consistent, effective, and constructive. As of August, our staff have been instructed to include several additional tasks, including off-site preparation and additional analyses for each survey. We have made clear to our surveyors that they can and should provide guidance to State surveyors during observational surveys. Over the past year, most of our surveyors have been observing State surveyors perform more than the minimum number of survey tasks that they are required to observe in order to improve the overall quality and comprehensiveness of oversight surveys. We have ongoing training underway to help our surveyors improve the quality of their oversight efforts. We are continuing to review procedures for selecting which State surveys to observe to look for ways to ensure an appropriate and standard selection process nationwide. And we will take other appropriate steps to improve national consistency as quickly as possible.

STATE ACCOUNTABILITY

We agree with the GAO's assessment of the parameters of our ability to ensure State survey agency accountability. Given these limits, the most critical factor for assuring State accountability is to establish definitive and measurable standards for the quality of surveys.

We have been working with State agencies to establish definitive, measurable, and reportable performance standards. We expect to complete them by the end of this year and to then use them as the basis for holding States accountable. For example, these standards will address:

- the timeliness of surveys;
- the timeliness of adherence to enforcement procedures;
- expenditure of funds; and
- adherence to survey policies and protocols.

There will be minimum criteria for each performance standard. We will provide standardized instructions for our regional office staff on how to evaluate whether a State

is meeting these criteria. And we will include definitions of inadequate performance and a listing of sanctions and remedies available under current law.

Once these standards are in place and States fully understand how they are being held accountable, we will redirect our State Agency Quality Improvement Program so that it is consistent nationwide and tied directly to these measurable and reportable performance standards. We will work with States that fail to meet the standards, using the appropriate remedy or sanction to help them improve when necessary. We also will evaluate the effectiveness of currently available sanctions, and explore alternative options for rewarding or sanctioning States based on their performance according to these measurable and reportable performance standards.

CONCLUSION

We continue to make solid progress in improving the quality of care and oversight in America's nursing homes. We agree that consistency in this effort is essential, and we are committed to consistency among our regional offices, clear guidance, better data systems, and measurable performance standards nationwide. This latest GAO report will once again help us to target and refine our efforts. I thank you again for holding this hearing, and I am happy to answer your questions.

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The CHAIRMAN. We will have 5-minute rounds for questioning, and when we get to Senator Bryan, if he would like some additional time for an opening comment, which we missed, I would be glad to give him that extra time.

Before I ask my first question, Mr. Hash, your response is very positive and upbeat, and we welcome that. I guess, since we are often critical of HCFA, we ought to say that your department committed itself to working with the staff and members of this committee on regular updates and our critical analysis of what you are doing, our ability to ask questions, our ability to criticize and keep dialog open, I think is very essential, so I thank you for doing that, because process is very important if there is going to be change in substance.

I will start with Dr. Scanlon. Your report indicates that HCFA requires only one or two comparative surveys per year in the vast majority of States and only three in the largest States, yet it seems that the comparative surveys have the most potential to adequately evaluate the performance of State survey agencies. Why has HCFA done so few of them from your study? And then I will ask Mr. Hash to respond or react to your response.

Mr. SCANLON. Mr. Chairman, a number of concerns have been raised about comparative surveys. We strongly believe that comparative surveys do provide the objective benchmark for measuring State agency performance.

The concerns which have been raised center on both the question of timing and the question of cost or burden. In terms of timing, there has been a lag between the time when the original State survey occurred and when the comparative survey occurs. As Mr. Hash indicated, they are required to occur within 60 days, and they generally occur within an average of 30 days. But there are questions of whether care in the nursing home has changed in that interval and whether or not you are getting an accurately picture from the comparative survey. We believe that that timeframe can be shortened, as Mr. Hash has indicated HCFA will do, so we can try to reduce that problem.

The second timing issue is one of giving feedback to State surveyors. If a comparative survey is done 2 months later, then when the State surveyors are later presented the results, they will not be able to relate strongly to what the findings of the comparative survey are.

The burden issues for nursing homes relates to the fact that after one survey done by State surveyors, Federal surveyors are immediately there, asking the home to go through the process again. For HCFA, the burden is due to the fact that comparative surveys involve more resources on the part of HCFA.

The CHAIRMAN. Mr. Hash, you have already indicated that you would mandate that these be done within 2 to 4 weeks, and you have also spoken very positively of comparative surveys. So maybe you could respond to the same question that I asked Dr. Scanlon.

Mr. HASH. Yes, Mr. Chairman. I think Dr. Scanlon actually identified the issue here. As I said in my statement, we are trying to strike the right balance between observational surveys where we accompany the State survey agency team and have an opportunity to directly observe and comment and train, in effect, the State sur-

vey team, as compared to the independent comparative survey that takes place subsequent to a State agency survey.

We have committed ourselves to reduce the timeframe for those comparative surveys to within 2 to 4 weeks of the state survey. It is important, I think, to note, Mr. Chairman, that that timeframe to some degree is important because we need the benefit of the State agency survey experience before we go back in. For example, we want to make sure that we are looking at the same set of nursing home residents, the same cases that the state evaluated during their survey. So there has to be at least some period of time after the completion of a State survey before the comparative survey could commence.

But I think the issue of feedback back on the results of comparative surveys to the State agency is an important one, and we are instituting a regular reporting requirement for our regional offices to ensure they report to the State survey agencies on a monthly basis.

The CHAIRMAN. Now, Dr. Scanlon, I think it would be good if I could have you react to that in the sense that you have heard how he is responding to your recommendations and how he interprets them. How do you think, if it happens as he says, that will meet your recommendations?

Mr. SCANLON. In terms of shortening the length of time between the surveys, we agree that the steps that HCFA is taking are very positive. We can also, though, suggest that in doing the comparative surveys, there is a question of whether we are asking HCFA to do too much. In terms of measuring the quality of the home and comparing that in the aggregate to what the State surveyors have found, it is potentially not essential that the entire sample of residents be the same in both surveys. Therefore, the timeframe could be shortened even further if one could use an independent sample.

It is also potentially feasible that the information about the state's resident sample could be expedited in the process so that the survey timeframe could be shorter.

With respect to the balance between the two surveys, we agree that maintaining both kinds of surveys is important. I would follow up on Senator Breaux's point about targeting. To us, the comparative surveys may provide the most valuable information in terms of where to target HCFA's efforts, and the comparative surveys may be able to identify the remedies needed to improve poor performance.

The CHAIRMAN. In regard to your suggestion of shortening the time, is that geared toward having the resources to use comparative surveys more often, or is there another rationale behind that, from your point of view?

Mr. SCANLON. Shortening the timeframe unfortunately is not going to reduce the amount of resources needed, but it will eliminate some of the criticism of comparative surveys, that is that they are measuring a nursing home providing care at two very different points in time, and therefore, discrepancies between the two surveys are attributable to that difference in time, not to differences in the quality of the measurement on the part of the State surveyors.

The CHAIRMAN. Senator Breaux.

Senator BREAUX. Mr. Scanlon, is the problem of your investigation one of not enough inspection of the nursing homes, or the fact that the inspections are inadequate in themselves—or a combination?

Mr. SCANLON. In terms of the number of inspections, there is the annual survey that is done by the State, and in some respects, as a comprehensive survey, that has been our focus. We get to see how well an annual survey that is implemented effectively would work.

We know from the work that we did earlier that there are not enough complaint investigations; that serious complaints were being backlogged and were not being investigated in what anyone would consider a timely fashion.

From the Federal perspective, we can definitely say that there are too few resources going into Federal surveys in the sense that when you have only between one and three surveys done per State each year, you really cannot have any type of valid indicator of the quality of the efforts of that State survey agency.

Senator BREAUX. We have, what, 17,000 or so nursing homes. How many of them are annually inspected?

Mr. HASH. Every one of them, Senator.

Senator BREAUX. Once a year?

Mr. HASH. Yes, sir.

Senator BREAUX. Who can tell me about the training that those inspectors receive? Mr. White, is that your area?

Mr. WHITE. I can certainly tell you about it. Most States put surveyors initially through an orientation period, which in my State is fairly intense—2 weeks of in-office training, and then we do a preceptorship for about 7 more weeks where they go out with different disciplines, follow them and observe what they do. They also get a week's training in Baltimore by the central office at the end of about a 6-month period. And then, at the State level, there is ongoing in-services that go on.

Senator BREAUX. So by the time someone walks into a State office and fills out an application to be a State inspector to the time he or she is doing inspections would be how long?

Mr. WHITE. About 7 weeks, but there is an extenuating circumstance. They must pass what is called the SEMQT test, which is a HCFA-mandated test, before they can independently inspect. That means that until they pass that test, which is at about 6 months, they must have someone review their work. They cannot sign off on their own work.

Senator BREAUX. And the guidelines that they must follow in doing the inspections are State guidelines, regional, HCFA guidelines, or what?

Mr. WHITE. The guidelines are primarily Federal. They are HCFA guidelines that come out in the State Operations Manual.

Senator BREAUX. How much difference, Mr. Hash, is there in the inspection requirements from region to region, in the 10 regions?

Mr. HASH. As Mr. White just indicated, we have a standard operations manual, so those guidelines are uniform across the country and across regions. It is fair to say, Senator Breaux, that both we and the GAO have determined that the application of the survey guidelines has certainly not always been consistent across regions

and across States, and that is clearly one of our objectives in putting into place a much more uniform protocol for the conduct of State surveys and a uniform protocol for our regional offices to conduct oversight surveys as well.

So we think it is important to bring more consistency both at the State survey level, in terms of how they do a survey, as well as how we oversee and evaluate the State agency surveys.

Senator BREAUX. Why or how did we decide to use the States as inspectors of nursing homes? Why didn't we just contract out with inspectors to do this work for the Medicare program?

Mr. HASH. I am not sure I have the historical answer for you, Senator Breaux, except that I assume that even before the existence of the Medicare and Medicaid programs, States as licensing authorities for nursing facilities, had inspection systems and State employees who conducted those kinds of inspections to determine that facilities were meeting licensure requirements. And I think that when the program was enacted in 1965, Congress took note of that and made a provision for us to contract with State agencies to carry out the enforcement of Federal requirements under Medicare and Medicaid.

Senator BREAUX. Have we considered contracting out the inspection program? If we are going to have national standards, why shouldn't we have national inspectors who answer directly to a central office?

Mr. HASH. It has been our view that it is important to work and establish a strong State surveyor approach to enforcement of nursing home standards, and we believe that the State agency process, in combination with us, is the best means for assuring quality of care and enforcement of Federal standards.

Senator BREAUX. Do we do that with hospitals?

Mr. HASH. No, sir. The Medicare statute requires the recognition of private accreditation bodies in lieu of the State survey agency. Not all hospitals elect the private accreditation, and if they do not, they will be surveyed by the same State survey agency.

Senator BREAUX. That is why I asked the question. I do not understand why, if you are a hospital, we inspect one way, and if you are a nursing home, we inspect another way. Do we inspect home health care? Probably not.

Mr. HASH. Yes, sir, we do.

Senator BREAUX. How do we do that?

Mr. HASH. That is a combination of certification either through our auspices, or we recognize a couple of private home health accreditation programs.

Senator BREAUX. It sounds like we run the inspection program differently each time, depending on who we are inspecting.

Mr. HASH. Well, much of that is driven by provisions in the law, Senator.

Senator BREAUX. Wouldn't it be better to have one, single way of inspecting the programs that Medicare has a responsibility for and do it all the same way?

Mr. HASH. I think consistency is important, and that is obviously what we are trying to achieve here with nursing home enforcement. There have been reviews—and Dr. Scanlon may be in a better position to comment on this—of private accreditation in the

hospital community. Our HHS Inspector General recently did one, with respect to the Joint Commission on Accreditation for Hospitals, and found inconsistencies and inadequacies in that area as well.

So, I do not think we have found a panacea for inspections that will give us confidence that there does not need to be careful and conscious oversight on a rigorous basis.

Senator BREAUX. Could I just ask Mr. Scanlon to comment on that?

Mr. SCANLON. Yes, Senator Breaux. In the work that has been done on accreditation, one thing we need to keep in mind is that accreditation would not necessarily create a uniform situation, because HCFA has used different bodies to accredit different types of providers. In each instance, they have had to find a body that deals with that type of provider and then be assured that its accreditation standards will be able to assure that there is compliance with the Medicare conditions of participation which are part of the statute.

In the case of nursing homes, as Mr. Hash has indicated, there have been studies done that have suggested that the accreditation standards for nursing homes do not comport presently with the Medicare or Medicaid conditions of participation. While that is something that could be fixed, there is still another issue which I think was brought out well in the Inspector General's report, that in comparing hospitals and nursing homes, the Inspector General noted that we are dealing with very different situations. In hospitals, we are dealing with a world in which there is an incredible amount of physician involvement, there is an incredible amount of family involvement on a daily basis, and people are there for the short term. In nursing homes, we are dealing with institutions which have much less professional involvement on the part of outside physicians and much less involvement on the part of families. And while we are relatively comfortable with the quality of care in hospitals, as the hearings of this Committee have demonstrated, we are not comfortable with the care in a significant minority of nursing homes. Until we become comfortable with that care and feel that we have established a floor of minimal acceptable quality of care, perhaps a strong regulatory approach which the current system involves makes the most sense for nursing homes.

Senator BREAUX. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Wyden.

Senator WYDEN. Thank you, Mr. Chairman.

Mike, I hope you will allow me to be skeptical for a minute, because I know that you are a dedicated and thoughtful public servant, but these issues were being debated when I was a public member of the Oregon Board of Nursing Home Examiners and I was director of the Gray Panthers, literally 20 years ago. OBRA-87 is supposed to have solved a lot of these problems. Now we have this sort of crazy quilt of consistent practices which is almost incoherent. I do not know what, on the basis of this GAO report, we could say to a family member or a parent who is trying to make sense of these surveys. I do not think they would know where to turn, and I am really very concerned about where we are headed.

The budget cuts are going to make it tougher for you. I think maybe one thing that would be helpful that we have not gotten this morning is your sense of how much it would cost to do these comparative surveys. I gather it is something that you want to look at, the industry is willing to look at. How much would it cost to do these comparative surveys?

Mr. HASH. I would be happy to get you a figure on the average cost of comparative surveys. It is a complete and full replication of the State surveys, and it is done by Federal surveyors, so it does require a very significant amount of our resources. There is no question about that.

We actually asked for an increase of \$60 million for this fiscal year in our appropriation to help increase our resources for these kinds of surveys, as well as other kinds of activities like the complaint surveys, which have been referred to as needing to be addressed on a more real-time basis.

Each comparative survey costs approximately \$8057.00. This estimate is based on data from 1999, during which we completed 93 comparative surveys. These surveys took approximately 15,710 hours to complete representing a total Federal salary cost of \$578,599. The total travel cost for conducting the surveys, including lodging, food, and transportation, was \$170,684.

Senator WYDEN. What would you think of the idea that I offered this morning of creating a watch list? Everybody understands that we are talking about a relatively small minority of the facilities. You can debate whether it is 5 percent or 6 percent—people have different numbers—but why not say that we are going to put those folks under special scrutiny; say that we have had an ongoing problem with this 5 or 6 percent, and they are going to get heightened, more rigorous inspections and surveys and scrutiny, and not create a system that puts 90 percent—all parties, the consumer advocates, you, and everybody else—does not put them through water torture? What would you think about the idea of HCFA creating a watch list so we could really zero in with our resources on the people who are creating the biggest problems?

Mr. HASH. I think it is a great idea, and we have it. We actually went out, as a part of the President's Nursing Home Initiative, and identified with the States in each State a minimum number of facilities that had troubled histories in terms of compliance with Federal requirements, and we put them in a special focus category where, instead of being reviewed annually, they are now reviewed at least twice a year. We think that that is a great idea, and that is where we ought to be focusing our resources, and we have already started that.

Senator WYDEN. Well, I follow this pretty closely, and I was under the impression that you had made some efforts in this area. Is this watch list available publicly?

Mr. HASH. Yes, sir.

Senator WYDEN. Good. Well, let us look at trying to make sure that the resources go in that kind of area, because my sense is that until we have a system that separates out those kinds of people—and I have not even heard you speak about this in the times that we have discussed this in this committee—we are not going to make the kind of headway we need to.

The last question I have for you is given the fact that we want to have flexibility for States, so we don't have a one-size-fits-all sort of approach, how do you envisage giving States some flexibility and at the same time trying to straighten out the inconsistencies in the survey process?

Mr. HASH. I think our efforts, Senator Wyden, to be fair have been aimed at bringing greater consistency. There has been a great deal of variability across States, as everyone knows from the work that this committee has had done for it. What we have done is to try to bring into the survey process the standard protocol that now integrates quality measures, things like patient hydration, nutrition, pressure sores, abuse of any kind—these have now been integrated into the survey protocol itself. What we are training the surveyors across the country along with the States, to do a more uniform job in actually applying the States survey instrument and to make sure that instrument focuses on the important issue, which is the quality of care and quality of life that the nursing home resident is receiving.

Senator WYDEN. Well, send the committee the information on the cost of comparative surveys and send to me how I can tell consumers and families how to find what amounts to the HCFA watch list, because I will tell you this is something of a revelation to me, and I can guarantee you I sure would have liked to have had that kind of information in the past.

Mr. HASH. And if I could, Senator Wyden, I want to also mention, because I want to make sure people know about it, that on our web site, www.Medicare.gov, we have a feature that has been up since the Spring called "Nursing Home Compare." On that web site, families and nursing home residents, for that matter, if they are able, can access information about the current status of nursing homes around the country, including the most recent Federal survey results. We are receiving very positive feedback from advocates and from ombudspersons around the country that this kind of comparative information, about the performance of nursing homes, is extremely important and useful to people in trying to—

Senator WYDEN. How long does it take to get a survey up on the web site? In other words, you are saying that you do a survey, and you get it up on your web site in 3, 4, months?

Mr. HASH. It varies, and we are trying to address that as well. Some States are very rapid in completing the surveys and getting them to us, and then we put them immediately up on the web site. Some States are taking longer. What this "Nursing Home Compare" web site does, though, is indicate very dramatically which States are lagging in the production of their reports for public consumption and which States are very timely in completing their nursing home survey reports.

Senator WYDEN. Well, it sure sounds to me like you should have gotten some of this information to Mr. Scanlon when he was preparing his report, because suffice it to say the picture that you are painting and the picture in the GAO report do not exactly square. So now that we have heard the information that you have given us, it certainly suggests to me that we are making some changes that I would like to see. And I am going to follow up, and I will be logging onto your web site in a hurry, you can be sure of that.

Thank you, Mr. Chairman.

The CHAIRMAN. HCFA responded after our hearing in July 2 years ago to our request to have this information put on the web site so that we would empower the advocates and families to be able to do a survey of their own before placing a person in a nursing home.

Senator Reed.

Senator REED. Thank you, Mr. Chairman.

Mr. Hash, I just want to ask what I think might be a basic question. In terms of focusing your scarce resources, do you view your mission as supervising the States or guaranteeing the reliability of every individual nursing home in the country?

Mr. HASH. I believe it is some of both. Our first obligation is to do everything we can to ensure the quality of care and quality of life for the nursing home residents. Obviously, we can only do that by having an effective State survey process.

Senator REED. Do you think that trying to do both sacrifices quality in both cases—that you are not effectively supervising the States, nor do you have the capacity to effectively supervise every individual nursing home?

Mr. HASH. I think the purpose of the many features of this initiative that we are carrying out is to really do all that we can, through the resources that we have, to best assure quality of care and quality of life for nursing home residents. That really depends on resources working with the States. You are right, we cannot do the survey ourselves. We could not survey 17,000 nursing homes annually with the Federal survey team. But with the States, we think this is a partnership that can work given proper guidance on our part and proper supervision.

Senator REED. Well, the report suggests that the data with respect to State performance is so inadequate that you really do not know what the States are doing—or, that is too conclusory and presumptive—but it is not clear what they are doing, and therefore, that tends to sort of undercut your notion that you are effectively getting the States to do their job.

Mr. HASH. Well, it is fair to say that we have not had a good data base for measuring the performance of State survey agencies. That is something that we are putting in place now so that we can actually have information across the country about deficiencies, about the status of nursing homes, and information that comes from the State survey itself. Without having that—you are right—we did not have a good basis for seeing, across the board, the lack of consistency that obviously exists.

Senator REED. Let me ask you another question in that regard. It seems also from the report or from additional information that you have very limited sanctions against the States even if you discover that they do not inspect well, they do not care about it—even worse situations. So that once again undercuts your ability to make the States not your partner, but the lead element in this effort.

Mr. HASH. We are limited, as Dr. Scanlon mentioned in his report, with respect to the kinds of sanctions that we have. But I think that before we think about new sanctions or different kinds of sanctions, our effort needs to put into place the kinds of performance measures and clear expectations of what we are going to hold

the States accountable to before we actually start invoking sanctions against them. And Mr. White actually made that point. It is important any time you are going to evaluate someone that you clearly establish what your expectations are and what your guidance is. Then you have objective measures, so that over time you have a basis to either sustain a sanction or not, depending on the performance measures that everyone has been put on notice about.

Senator REED. Thank you.

Dr. Scanlon, might you comment on this line of questioning about the focus between the States and individual nursing homes, and also the fact that there is very little data to give real insight into how well the States are performing, and finally, what do you do if you have data and performance standards and they are not measuring up?

Mr. SCANLON. Well, with respect to the first, as Mr. Hash indicated quite accurately, the idea of HCFA trying to undertake the direct survey of all nursing homes themselves is something that is not really feasible to imagine. We would be talking about a much, much larger HCFA. But the role that one has to play when one contracts out for a function does not eliminate the responsibility to assure that their function is being undertaken well. What we are seeing today is the issue of the difficulty of overseeing contracts.

We do have in this oversight process a real scarcity of data, and without those data, we are going to have difficulty in terms of ever being comfortable that we are getting what we are contracting for.

Having clear expectations, having adequate data in order to impose remedies or to use remedies or sanctions is a critical piece of making this process more effective.

Now, the sanctions that are on the books are in some respects very severe and therefore potentially not very usable. We do not have to necessarily focus on them but focus on how we can work with the States in a more collaborative way when the information demonstrates that performance is not adequate, to get the states performance to improve.

The States have a major stake in this as well as the Federal Government. It is their residents who are in nursing homes; they are as much concerned, as the Federal Government is about the quality of care of nursing homes, so that when we have identified the problems, we can be effective in terms of working toward some solution.

Senator REED. Is it fair to say that the emphasis, then, should be on developing the kind of data, State by State, and promulgating the performance standards so that HCFA's major focus could be not on the quality of individual nursing homes and providing in an unsystematic way about individual nursing homes, but actually making it clear to the States that their job is to ensure the States are doing their job?

Mr. SCANLON. Ultimately, HCFA's responsibility is to assure that the State agency is doing its job. Its information about individual nursing homes is only secondary. The issue is how well is the State agency doing in reviewing all the homes within the State, because then we will know where we need to concentrate our resources.

Senator REED. Do you think that HCFA is organized that way today and focused on that mission today?

Mr. SCANLON. I think we are very heartened by what Mr. Hash has indicated in terms of the steps that they have taken since this Committee has started, as well as since they released their report a year ago on nursing home oversight, to try to move in the direction and to the point where we need to be in terms of making improvement. We are not there today, but we are moving in the right direction.

Senator REED. Thank you very much.

Thank you, gentlemen.

Mr. Chairman, thank you.

The CHAIRMAN. Thank you, Senator Reed.

Senator LINCOLN.

Senator LINCOLN. Thank you, Mr. Chairman.

Mr. Hash, I know just from the fact that I have called you on several occasions that you have done a good job while the administrator has been out on maternity leave, and I certainly appreciate all of your hard work and, as Senator Wyden said, your dedication to public service. And I hope she and everyone in the family are doing well.

Mr. HASH. They are, and she is back this week.

Senator LINCOLN. Good. That's great.

I know from the implementation of my office that oftentimes it is just human nature that we can be territorial. With five offices in Arkansas and my office here in Washington, in order to get my staff to be the best single team that it can be, there are many initiatives that I do—an annual retreat, making sure that we have a buddy system in place, making sure that each staff person knows what his or her responsibilities are and what their mission is—we have that in writing, and I think it is helpful to them and to everybody to be able to work as a team.

So I wonder how often your HCFA regional directors and your directors of Medicaid and the State operations come together for training.

Mr. HASH. They actually come together now in a conference call, electronically, as it were, once a week on these issues. So the regional offices and our Center for Medicaid and State Operations, where this activity is located in HCFA's central office are actually in weekly communication. We have other—

Senator LINCOLN. Is that by chance, or—

Mr. HASH. No. That is a scheduled meeting, and it is focused on implementation of the Nursing Home Initiative, so it is a cross-cutting team type effort that involves regional office and central office leadership. We have put this in place so that we can bring greater consistency in our communications. Just as you described with your own district offices, we want to make sure that they are all aware of what our priorities are and what our guidelines and expectations are with respect to the State survey activities.

So we are doing that, and we are doing training sessions for Federal surveyors—for example, the Federal surveyors were in our regional offices in September, and we had a national training session for them, which was basically, again, looking at the new protocol for evaluating the State agency survey activities. They have helped us with the States to put in place performance measures—seven of them altogether—for State survey agencies, and these are going to

be the performance measures that we are going to use to evaluate the states. For example are they doing the annual surveys in a timely manner? Are they meeting the goals for following up on complaint surveys? Are they entering their data into the proper data system in a timely manner? Are their budgeting and allocation decisions made in a uniform manner? Laying this out is really the predicate for having more consistent performance by the State agencies, and it is the only fair thing to do when it comes time to hold them accountable for their performance under our contracts.

Senator LINCOLN. Dr. Scanlon, in talking about the comparative surveys and the method used there and doing that on a more wide-scale basis, what do you think—and you are talking about going from 90 to 60 days, is that right? I would be interested to hear from you what you think is the ideal time to lapse between the State and the Federal surveys?

Mr. SCANLON. I think the ideal time is to do it immediately following the State—

Senator LINCOLN. Two days? Four days?

Mr. SCANLON. Absolutely. Because then we are measuring essentially the home in the same condition as it was measured by the State surveyors.

The factor that creates the delay now is one of wanting to target those surveys on particular homes and needing information from the State survey in order to target those surveys.

If one would be willing to use information from prior surveys as a targeting proxy, then it would be possible to do them immediately following the departure of the State surveyors.

Senator LINCOLN. I do not know what kind of complication that presents for the industry side in terms of preparation because I know it does require them to prepare surveys and other things—I would imagine that would certainly be taken into consideration.

Mr. SCANLON. Well, actually, we would like it so that the industry did not prepare for surveys, that the quality of care was the same year around, so when the surveyors arrived, they were observing a typical day in a nursing home. Therefore, there may be an effect on the industry of having the surveyors there for a longer-term basis, but I think it is a question of two doses of medicine, and would you prefer to take them simultaneously or have an interim between them.

Senator LINCOLN. But in your professional opinion, you think that the less time that elapses obviously gives you that more common appearance, everyday survey?

Mr. SCANLON. It would be helpful in terms of fulfilling the primary purpose of the comparative survey, which is to give us a validation of the State survey's measure of the quality of care in that nursing home.

Senator LINCOLN. Finally, Mr. White, as someone who has literally performed hundreds—of surveys of nursing homes, how much consistency is there among surveyors, and how often do two different surveyors look at the same potential problem and report in the very same way? To me, that seems almost impossible.

Mr. WHITE. Well, your point is very well-taken, and there are differences among surveyors. In any organization, you will have folks

who are very strong and folks who are somewhere in the middle as well as weaker folks.

One issue that we have had with comparison surveys is that the assumption is that the HCFA surveyor coming in is going to be stronger or more capable than the folks they are looking at, and that may not be the case. The State surveyors may do a better job, and the comparison survey may not point out the problems with the State but may—you know, HCFA also has strong surveyors, surveyors in the middle and weak surveyors, and in the comparison survey process, you have got to compare apples to apples, and not only do you have to do it almost simultaneously, but you have to take very similar samples, and you also have to have the same disciplines onsite. If the State sends a pharmacist, and HCFA does not send a pharmacist, there are going to be differences, because pharmacists are more skilled. Certainly, even within States, there are differences; within HCFA, there are differences, and it leads to an awful lot of subjectivity.

Senator LINCOLN. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Lincoln.

Now, Senator Bryan, do you have an opening statement that you would like time for as well?

Senator Bryan. Mr. Chairman, I will waive an opening statement and just go to questions, if I might. I thank you for the opportunity, however.

Perhaps, Mr. Hash, you can answer this. How is it determined how many surveyors each State is entitled to have? That is to say, is there a Federal funding formula? Is that something that is done jointly with the States and the Federal Government? Maybe you could very briefly describe that process. Let me just give the reason why I ask that.

The information number of surveyors we have in Nevada, a State that is geographically quite vast, with tremendous distances in between facilities, is the full-time equivalent of 13.75 positions. There are 49 nursing home facilities, and I am led to believe that in addition to those responsibilities these surveyors also have to do 42 hospitals, 21 intermediate care facilities, 73 home health facilities, and on and on. I do not want to take all my time by asking the question, because I want the response. The first question is, could you describe, in terms of how it is determined, how many State surveyors there are going to be, and what the Federal funding formula for that is or how that is determined.

Mr. HASH. It is not done by specifying the number of FTEs that each State agency should have. Actually, States are funded for this activity in two ways. One is there are Federal funds to the State survey agencies that come directly from the Medicare program to support the costs of ensuring that Medicare surveys are properly done. In addition, States also survey under the Medicaid program, and that is a combination of their own revenues, as you know, plus Federal matching funds.

So it is the combination of what States draw down in the way of dollars from matching through the Medicaid program and the Medicare direct payments that actually create the budget for each State survey agency. Then, what we try to do, is to help the States

in the allocation of those resources to specific categories of activities.

Actually, Mr. White, I am sure is much more skilled than I am at answering that question, but from the Federal perspective, we do not prescribe the numbers of individuals that must be present.

Senator Bryan. I see. Dr. Scanlon, I would think that that in itself would lead to a wide range of how the States would handle those responsibilities. Some States, in my experience as a former Governor, would probably be very aggressive in terms of the kinds of matching funds they would provide; other States, for whatever reason—budget constraints and other priorities—might handle it differently. Would that account for a wide disparity in terms of how effective these survey programs are?

Mr. SCANLON. We certainly think it is a factor in terms of the variation. In looking at the complaint process in the report that we issued earlier this year, we found that there were wide differences in the resources that States committed, and consequently in how quickly they responded to complaints and what they found and how extensive the review they did when they responded to complaints.

Senator Bryan. Am I correct in drawing the conclusion that there is no formula to determine for a State with "X" number of citizens in nursing homes, that there should be a certain number of surveyors or a certain number of hours committed to the survey process? That is all essentially left up to the individual States working through this formula that Mr. Hash has explained to me?

Mr. SCANLON. There is no formula. There is certainly no formula in terms of specifying the funding. There have also been no studies that have shown exactly what is required in terms of an effective and efficient survey. Part of that is going to vary depending upon the type of facility and the types of residents there will be in a facility. But that kind of work to identify what would be the right level of resources has not been done.

Senator Bryan. Senator Breaux asked a question, and I am not sure I heard your answer, Dr. Scanlon. Essentially, his question was is there a lack of personnel or a lack of quality. Let me ask you the first part of that. As you look at the deficiencies you have reported on, is it that the States are not hiring or engaging enough surveyors to conduct these surveys? Is that a significant or major problem, or is that just a factor?

Mr. SCANLON. We have not looked at the staffing levels in the States directly. Certainly, as you have heard from Mr. White and Mr. Hash, concerns about resources are present on the part of both States and HCFA. We have been concerned that we need to make the most effective use of the resources we have, and there have been a number of instances where we have pointed out how resources could be used more effectively.

Pursuing additional resources and applying them is probably required because of the fact that we have so far to go in terms of achieving adequate levels. The comparative surveys that I mentioned where we have one to three per State is certainly not adequate to be able to measure the performance of a State agency. We are going to need significantly more.

The complaints in surveys that we identified before where complaints were being backlogged for long periods of time even though

they involved actual harm to residents—we have a standard now that says that those should be investigated within 10 days. It is going to be a resource issue in terms of making sure that happens.

Senator Bryan. When we use the word “resource,” that is a fairly general term. Let us talk more in the idiom of the street. Are we talking about bodies—is that what we are really talking about?

Mr. SCANLON. We are talking about individuals being able to go out and investigate these things.

Senator Bryan. In my own State, and with its geography, it takes some time to get to the more rural parts of our State. I suppose that is not a situation unique to Nevada. But responding to something in Reno or Las Vegas, where you have people right there, is a much easier proposition than responding to a concern that you might have in a nursing home that is 200 miles from the major metropolitan area, and because there may only be one or two nursing homes, you do not have a surveyor who actually lives in that area; he or she probably makes the rounds periodically.

Does that touch the matter?

Mr. SCANLON. That is correct.

Senator Bryan. I know my time is up, but the chairman was kind enough to give me an extra minute or two because I waived the opening statement.

Let me ask you this. If you were asking this Congress for additional help with the problems which have been laid out as our colleague from Oregon has pointed out some of the frustrations that he has had. What would you ask us to do in terms of priorities one, two, and three, and be somewhat specific?

Mr. HASH. I think the first priority, Senator Bryan, is resources, meaning in this case, to use the vernacular—dollars—to support the enforcement and oversight activities of HCFA in this—

Senator Bryan. You are telling us that you do not have enough money, in your judgment, to do that because of a lack of dollars?

Mr. HASH. Yes, sir.

Senator Bryan. OK. The second priority.

Mr. HASH. The second thing is that we need assistance in the effort to work with the States and bring them into greater consistency in their performance, and that really involves putting into place a system that can hold States accountable for their performance. And we are doing that, but I think from our point of view, that is a second high priority for us.

Senator Bryan. OK. Is there anything that we are failing to do in helping you to implement that priority?

Mr. HASH. I think not, Senator.

Senator Bryan. There is no congressional impediment? I guess you are getting the sense here, from the questions of my colleagues, that we want that done.

Mr. HASH. Yes, sir.

Senator Bryan. You have got that message, sir?

Mr. HASH. I do have that message, yes.

Senator Bryan. Indeed. And now, No. 3?

Mr. HASH. No. 3 is I would ask for some recognition that we are trying to make the progress that we can here. We have taken on a very large set of tasks here. Just to give you one example of something that has come up quite unexpectedly and has required

a lot of resources, and those are the monitoring protocols for nursing homes that are experiencing financial difficulty or bankruptcy in some cases. That has required us, again with the States, to put together a separate protocol for monitoring what is actually going on in nursing homes that are experiencing financial difficulties. We want to know whether the food is arriving on time, the employees are showing up and being paid for work. This is taking a special effort on our part, along with all of the 30 other initiatives that we are putting into place.

So, I just want to make sure that as we recognize that we have a long way to go in getting to where we want to be, that we are making progress, and we are making it on a variety of fronts. And to be frank, I think that some of the things we talked about a year ago that were problems are not being talked about today because we have addressed them, and we have made progress on them.

So I am not saying all that in a defensive way. It is just that this is a very challenging area for all the reasons that have been talked about today, and I would hope you would recognize it when we are making progress in various areas.

Senator Bryan. Thank you very much, Mr. Hash, and thank you, Mr. Chairman, for allowing me to go over my time. It is tempting to get into the BBA discussion, but I know that that is for another committee and another time, when you and I can share the opportunity to discuss that together.

The CHAIRMAN. Yes. We want to make sure we plan an opportunity.

Senator Bryan. Yes. Thank you, Mr. Chairman.

The CHAIRMAN. Before you go—and Senator Wyden, I will let you start the second round—again, Mr. Hash has mentioned a move that he has taken when he answered your third point to a request that we made by this committee to his department, to make sure that in bankrupt institutions, HCFA would push the States to make sure everyone of those residents would be taken care of, preferably in the home that had gone bankrupt, so they do not have to be moved and experience that trauma.

Senator WYDEN. Thank you, Mr. Chairman. I just have one question.

Dr. Scanlon, you go back to your office this afternoon, and you log onto the HCFA web site. What is the quality of the nursing home survey data this afternoon on the HCFA web site?

Mr. SCANLON. Unfortunately, I cannot tell you because, as we have indicated, the variation in the level of deficiencies across States is quite staggering, and we do not know whether it is because some States have truly good homes with almost no deficiencies, or whether they are just underreporting the deficiencies in those States.

I would feel most comfortable if I were a user in only comparing homes in a local area and saying that one that has fewer deficiencies may be better than another one in that area, but when it comes to comparing Oregon to any other State, I am at a disadvantage in using that web site, because we have not had the validation of the surveys that we need.

Senator WYDEN. Because it is very hard for me to reconcile this rosy picture that Mike is painting this morning with your report,

and I am going to go back and use this web site. I gather you are saying there may have been some improvements, but overall, you cannot measure the quality of the survey data. I have never heard HCFA announce a watch list before, and I hope that we will hear you doing that kind of thing in the future, because I can tell you that the consumer groups that I work with will be intensely interested in knowing who that small percentage of facilities are and to hear that, on an ongoing basis, they are getting much more rigorous inspections.

Mr. HASH. Senator Wyden, if I may, I need to correct what I said to you, because I misspoke. We have not made that list public. It does exist. The reason we have not made it public is that we did not want to cause undue alarm to individuals who were residing in those nursing homes or their families. We have worked with the States to identify these facilities and to have them more frequently surveyed, but I misspoke when I said the list has been public.

Senator WYDEN. The chairman has been very kind to let me start, and I will tell you I just find this curiouser and curiouser, because if there is a watch list—and we have, since I asked the question, even tried to get a sense of what the industry thinks about this, and they are confused as to whom gets on the watch list. Now you have told me that there is a watch list, but it is not public. So I just hope we can start this out, and I am going to start by logging onto your web site to see if I can make some sense out of the survey data. I hope that you can clarify for us how this watch list, first, is created, because there seems to be some confusion about how that comes about; and second, if there is one, I would hope that it would be made public when there are clearly defined standards for determining who gets on it, because I cannot think of anything more useful to the consumer and the public than knowing who the people are who are the problem.

But as I said earlier, I knew Mike Hash when he was sitting behind Chairman Waxman, and he is a good man, and the question is are we going to change things significantly from the way they were 20 years ago—because I come to Chairman Grassley's hearings, and these debates are not real different from the ones I was sitting in on when I was director of the Gray Panthers and when I was a public member of the Board of Nursing Home Examiners, and we were debating surveys, and people said they were inconsistent, there is a mish-mash, and we cannot figure out what is expected of them. So we have some work to do based on the GAO report, Mr. Chairman.

I thank you for letting me ask the question.

The CHAIRMAN. And obviously, we will do our work, and we will do it together.

Senator WYDEN. Count on it.

The CHAIRMAN. Hopefully, we have made some progress—at least, we have raised it in everybody's minds as a very important point, and we have had the proper follow-through.

Mr. White, I will start with you—obviously, you are no potted plant, or you would not be president of your organization. And you have a lot of experience to bring to this, and I suppose I should have told you that any time you wanted to comment on anything that Mr. Scanlon or Mr. Hash said, you could do so.

Let me start with your testimony. You mentioned that regional offices differ in their handling of facilities that continue to have a D-level deficiency 6 months after an annual survey that found that the nursing home was out of compliance. As I understand it, the States must terminate a facility from the Medicare program if that facility continues to have a D-level deficiency 6 months after an out-of-compliance annual survey.

Is that an accurate statement of the rule?

Mr. WHITE. Yes, sir.

The CHAIRMAN. To give us a better picture of what this means, let me ask you to give some examples of D-level deficiencies.

Mr. WHITE. Well, just as a little background, D-level basically means that there is no actual harm, with a potential for more than minimal harm. D-level is also an isolated deficiency, where you have an isolated pattern and widespread deficiency, so we are talking about isolated deficiencies that do not harm residents but do indicate more than a minimal potential for harm.

Things that come to mind are dignity issues, possibly medication errors—not necessarily significant medication errors, but someone may not have gotten a vitamin or something like that—things that—I am trying to think; it is not easy to come up with deficiencies in your head—

The CHAIRMAN. I am not sure you have to come up with every one of them. We just want some examples. And I do have a follow-up to that. I think maybe you have given us that.

It is possible, then, if I understand it correctly, that if two nursing homes in different parts of the country have the same identical problem, one will be terminated, the residents moved and experience all kinds of trauma, while at the other, we could just have business as usual.

Mr. WHITE. Well, most advocates, many regional offices, most States, do not believe that nursing homes with isolated deficiencies at the end of 6 months should be terminated. I have terminated three or four in the last couple years, and family members are outraged when you have got an isolated deficiency, and you have another nursing home down the road that has 20 or 30 pages of deficiencies and is being given an opportunity to correct those deficiencies.

So because most regional offices, most States, advocates, providers—nobody really thinks that the punishment in this case fits the crime, so they have found all kinds of ingenious ways to get around it. I had an email last week from the State saying that they had been asked to go ahead and allow the facility to correct the problem onsite and bring them back into compliance. That is one way of doing it. I have outlined five or six different ways that folks do that.

The CHAIRMAN. OK. Let me suggest to you that there seems to me to be, at least as a matter of policy, some sort of inconsistency. Is this something that should have been discussed at the weekly telephone conferences long ago, before it would become such a national issue?

Mr. WHITE. I think it sort of evolved as a national issue, and we have discussed this at some of our meetings, and we have discussed it with HCFA at some of our meetings. But the whole struc-

ture of the enforcement process is set up in such a way that law and statute require that if there is not substantial compliance at the end of 6 months, they be terminated. So it is locked in, but yes, it should be something that is discussed and dealt with in the future, I think.

The CHAIRMAN. Yes. Let me have the basis for your comment with a question that I would have asked you anyway. Is it HCFA's policy to terminate a facility under these circumstances; and second, how is it that some regions are able to implement the policy one way consistent with HCFA policy and other regions may implement it in a different way? If that is true, clearly, these differences in implementation of policy are not minor. If you disagree, please say so.

Mr. HASH. Mr. Chairman, I am glad you asked me that question. This is a very good example of one of the issues that was addressed by the Nursing Home Initiative of a year ago. As you will recall, when the GAO presented its report last summer, one of its criticisms was the fact that in some areas, State survey agencies took oral and verbal assurances about the removal of deficiencies without actually having a site visit to determine that. The standards have been consistent all along that if a facility has a D-level deficiency or higher in our hierarchy of deficiencies, that represents a facility which is not in substantial compliance with the nursing home requirements, and as Mr. White stated, it is required that within 6 months, a facility that has had a serious deficiency followed by a D-level or above deficiency has to come into compliance.

We instituted the revisit policy last fall as a part of our Nursing Home Initiative so that we could be assured that if someone had a continuing deficiency that we had someone going in there to verify that the deficiency had been removed.

If, in fact, this is not being complied with on a uniform basis nationally, that is our responsibility, and we need to do something to make sure that this policy is applied uniformly.

One thing we should be paying attention to is when a facility is moving through a period when it is on notice and is subject to termination within 6 months if it is not in substantial compliance, is that the revisits should be earlier in the process. We do not want to be at a point that is 2 days away from the 180-day clock and determine that a D-level deficiency has not been removed. We want to make sure that facilities have the time to remove them.

But Senator, if a facility has had a D-level deficiency for 4 or 5 months and has not remedied it, they are not likely to remedy it, and therefore, we think the obligation here is to protect the resident and make sure that the facility does not continue to put patients in jeopardy as a result of that continuing deficiency.

The CHAIRMAN. OK. Let us follow up on this and go back to the GAO report. We have heard these reports uncover deficiencies in a number of areas for which regional offices have responsibility, and we have also heard today that regional offices are inconsistent in their evaluation of State survey agencies as well as in how they monitor and evaluate these other very important partners in providing quality service to our elderly citizens.

To what can we attribute the inconsistency—and maybe you could follow up with what steps HCFA takes to make sure that

there is consistency in regional office implementation of your central office policy.

Mr. HASH. If I could take the first one in terms of consistency in the evaluation of State survey agencies—if that is the first part of your question. I think that is a function of our not having put in place measurable and verifiable performance measures that we could then hold State agencies accountable to. That is why we have entered into this dialog with the State agencies to develop those seven performance measures, put them into place, collect the data, independently verify the data, and then hold States accountable. We think that is the right plan for dealing with consistency in the evaluation across regions of State agencies.

Now, with respect to the performance of our regional offices and whether or not they are clearly and consistently implementing our policies, that is a function of our management and oversight of our regional offices. That is why we have instituted a number of structures to increase the communication and the cross-training, the cross-survey teams that get people from different regions participating in surveys outside their normal areas. All of this is designed to bring greater consistency in the performance of the regional offices.

The CHAIRMAN. Only time will tell, Dr. Scanlon, but do you see that as positive movement in the direction of accomplishing what you are reporting to us today is a fairly bad situation?

Mr. SCANLON. We think, Mr. Chairman, that they are movements in a positive direction. As we have noted in our work here as well as in our work on other topics, including the issue of Medicare+Choice plans in work for this Committee, regional office inconsistencies are problematic in terms of the administration of the Medicare program. But in this area as in some other areas, HCFA has started to take some steps to try to reduce those levels of inconsistency.

As Senator Lincoln indicated, it is a challenge when you have multiple offices and a central office to achieve consistency. So that while we are heartened by this, we also feel that it is important to remain vigilant both on HCFA's part and on the part of the Committee in terms of whether this can be accomplished.

The CHAIRMAN. Back to you, Mr. Hash. In response to questions from our March hearing this year, you indicated that HCFA was adjusting resource allocation to enable States to give the appropriate priority to responding to complaints. Steve White commented that HCFA is imposing performance standards but not resources to meet them. This implies that HCFA has not adjusted resource allocation sufficient to cover their expectations. Has HCFA adjusted resource allocations, as you indicated? Is there some reason why States do not know about the adjustment?

Mr. HASH. Well, there have been adjustments, Mr. Chairman, but I think Mr. White testified that he does not feel they have been adequate to meet the needs of the various requirements that we have imposed on the states. I think there is a good deal of truth in that, in the sense that we are trying to gradually make a case for increasing the resources that are available to implement this Nursing Home Initiative. As I stated earlier, we do not have sufficient resources now to implement it in the way that we and the

States want to implement it. So, the short answer is we do need more resources; we have tried to do the best we could within the resources that we have available to us, but they are not sufficient to do this in the manner that we would like to do it.

The CHAIRMAN. First, let me say that as a person who has tried to get more resources, I am not going to dispute that maybe you have a legitimate case for more resources, and I suppose it is another budget year before we can do more in that area, but we have put tens of millions of dollars more into that.

Maybe, then, I should follow up on what you said with a question to Mr. White about the adjustments. Do you feel that there would still be problems with adjustments with more money? In other words, is it adjustments as you see it within a certain pot of money that is the problem, or do you think it is just more money in the pot?

Mr. WHITE. Well, there are two problems, Mr. Chairman. The first is getting the money allocated to the States. The second is the States may never get the money in place to use it.

This year, HCFA did something which was really good. They allowed States to send in budgets for the amount of money they needed to run the program. I think the amount came in at about \$235 million. The allocation is well below that.

Our concern is that the workload keeps coming before the money gets there. We came through a period of about 7 or 8 years where the allocation was about \$146 million. Last year, it went up some, and this year, as it stands right now, it is going to go up incrementally, but the workload is outpacing the money considerably.

The CHAIRMAN. My staff requested that we follow up on something you just said. You said that the demands come before the resources.

Mr. WHITE. Yes.

The CHAIRMAN. Expand on that a little bit, please.

Mr. WHITE. For example, Senator Grassley, in the last 2 or 3 months, we have gotten monitoring of facilities that have gone into Chapter 11; we have gotten Y2K; the complaint procedures have been released. A number of States are already not meeting the 12-month survey schedule. So we are already behind, and we continue to have things added to our plate. Individual States are making individual decisions about what not to do. For example, I cannot get to my complaints to do them. I am still meeting the 12-month survey schedule, although it is sliding, but I cannot get to the complaints in a reasonable amount of time, and there are some pretty serious things coming in over our complaint hotline.

The CHAIRMAN. Could I go to Dr. Scanlon again for a new point, and it is based on perhaps not fully understanding or at least not correctly understanding exactly who is responsible for what in the implementation of Nursing Home Initiatives, particularly with respect to the matter of ensuring consistency of implementation across the 10 or so regions. What I will be trying to get at with some questions is where the locus of responsibility for ensuring consistency in the application of these initiatives lies, and whether some inconsistencies across regional offices that the GAO has documented can be attributed at least in part to the way HCFA is organized.

You noted in your testimony that the staff of the Center for Medicaid and State Operations in HCFA's central office carry out their coordinating roles through many informal meetings with regional offices. You also noted that if there is a disagreement between the Center and the regional office, it cannot be informally settled at a lower level—it can only be resolved at the level of the HCFA Administrator.

Is it your understanding, then, that the Center for Medicaid and State Operations is responsible for ensuring consistency in implementing across regional office?

Mr. SCANLON. It is our understanding, Mr. Chairman, that while they have the responsibility for trying to ensure consistency, they do not have the direct authority to ensure it. Ultimately, the responsibility and the authority reside in the Administrator, and in this instance, the delegation of responsibility, to the Center, with the authority delegated to the regional offices, creates a situation where there has to be cooperation between the Center and the regional offices. If that cooperation is lacking, I think find that we have the inconsistencies that we have observed.

The CHAIRMAN. To follow up, to your knowledge, has the Center tried to ensure that the regional offices implement the Nursing Home Initiatives in a consistent manner? What actions have they taken to this point to ensure that the regions are implementing these initiatives consistently?

Mr. SCANLON. In our work looking at the implementation of the initiatives, we feel that the Center has not been aggressive in terms of trying to ensure that the initiatives are being implemented across the regions. As we noted in the hearing last June, the Center was accepting from the regions information that States were fully compliant with certain initiatives, when in reality, the States were not, and the regions in some instances knew that they were not fully in compliance.

It takes a more intensive, more aggressive oversight to be able to assure that there is full compliance with the initiatives.

The CHAIRMAN. Mr. Hash, could you please take note of the organizational chart on the easel? From that, the Center for Medicaid and State Operations does not seem to have the authority over the regional offices, and the GAO report notes that in the event there is a dispute between regional offices and the Center for Medicaid and State Operations, it would have to be resolved in the executive office. This arrangement would seem to reduce the ability of the central staff to get the regional offices to implement the policy that the Center wishes. Doesn't it really mean that the executive office is responsible for ensuring that the regional offices are carrying out all of their responsibilities, and not just in the sense that the administrator is always responsible for everything, but in a very practical sense?

Mr. HASH. Mr. Chairman, in a real practical sense, the activity to ensure consistency across the regions is, as Dr. Scanlon said, in the Center for Medicaid and State Operations. At HCFA, as a result of this organizational pattern you see here, much of our work is done in working groups across components where collaboration and cooperation between central office components and regional office activities are key to our success in implementing any policy.

We have what the organizational theorists refer to as a "matrix organization," and as a result, it requires collaboration and cooperation across organizational components. If we have not successfully achieved consistency across the 10 regional offices, ultimately, of course, the responsibility is at the administrator's level. It is also a failure of our collaboration and cooperation activities to achieve that—because we have lots and lots of examples where, working with the regions, we are working in teams of individuals who technically do not work for one another, but who collaborate and cooperate on policy implementation and oversight. That is what this situation is. I think it is improving—it is not perfect. It requires vigilant oversight and accountability on the part of not only the Center for Medicaid and State Operations, but also the Administrator's office as well. That is why I spend a considerable portion of my time overseeing and getting involved in this, as does the director of our Center for Medicaid and State Operations.

We have biweekly meetings, Mr. Chairman, involving me, the leadership from the regions, and from CMSO to discuss the implementation issues associated with our Nursing Home Initiative.

The CHAIRMAN. OK. I believe—and I am not denigrating anything you have said—I believe you are saying that even though it may not make sense on the chart, it is working. But also, you did say that through these extra efforts that you are making, it is beginning to work. Isn't it—and I am not a student of administrative organization—but wouldn't it be better to put it in an organizational structure so there is no doubt where the authority is and so that it can work—or is that too simple an answer to a bigger problem that you understand that I would not?

Mr. HASH. No, sir. I think you understand it correctly. You may or may not be aware that HCFA reorganized into this structure in July 1997, so we are just past 2 years in this structure that you see before you.

The CHAIRMAN. That was a direct result of the President's initiatives?

Mr. HASH. No, sir. This was a complete reorganization of HCFA.

The CHAIRMAN. Oh, I'm sorry. The President's initiatives came out in July 1998.

Mr. HASH. That is correct.

The CHAIRMAN. OK. So there is no relationship?

Mr. HASH. No, sir.

The CHAIRMAN. OK.

Mr. HASH. But that new organization, as any new organizational structure in a large organization like HCFA, requires some period of settling in and getting used to and making that organization function well. This is a very different structure from what preceded it, and as a result, we have been making efforts not only in this area but in a lot of policy areas—in fact, Dr. Scanlon referred to some of them that the GAO has looked at—to make sure we can make this organization work.

I believe this is an effective organizational structure and can be made to work. It just requires diligence and accountability, and that is what we are trying to instill.

The CHAIRMAN. I have to go back, then, to Dr. Scanlon to give us your perspective on this description that you have heard. How

should we understand the nature of the relationship, then, between the Center and the regional offices?

Mr. SCANLON. Well, Mr. Chairman, we have actually looked at the HCFA reorganization on a number of occasions for the House Ways and Means Committee, and we agree with Mr. Hash in terms of the reorganization being a structure that has a considerable number of merits, but I think it also has a number of potential weaknesses.

The issue of cooperation and coordination is critical to making this matrix-type organization function. It is not just with respect to the Nursing Home Initiative; it is with respect to many other things that HCFA does. One problem that we noted initially when the reorganization was put into place was the fact that the unfamiliarity with who was responsible for what meant that it was very difficult to bring those teams together to be able to accomplish a task.

What we are seeing here is a problem in the nursing home area, where we do not feel that the coordination and cooperation has yet overcome the difficulties of achieving consistency in these initiatives. There are some aspects of this matrix organization which we think have very strong positive attributes. Whether the relationship between the Center and the regional offices has similar advantages, we are uncertain at this point.

The CHAIRMAN. Has the GAO found in other HCFA projects inconsistencies across the regions of the kinds that you report to us today—and maybe an example or two, if they exist?

Mr. SCANLON. Yes, Mr. Chairman. For this Committee, I have testified on the issue of the information campaign and the marketing materials that are available for Medicare+Choice plans. The review process across the regions has been different, and the plans have voiced their concerns about differences in these reviews. This is again an area where HCFA is taking steps, and it is our understanding will try to address that.

We have also looked at oversight for the Part A and B contractors who actually pay fee-for-service claims, and we have identified that different regions have very different approaches to how they evaluate those contractors. Contractors who have had experience with more than one region point out some of these significant differences. Again, it is an area where HCFA has been recently taking steps to try to address some of that inconsistency.

The final area I would mention is a hearing that you attended in the Senate Finance Committee on the Medicaid School-Based Service Program, where regional offices had very different approaches to what services they would allow Medicaid to pay for and what kind of information they required before they allowed those services to be paid for.

The CHAIRMAN. Mr. White, you will be the focus of my last question, and it comes directly from something you said about the complaint survey. Can the State long-term care ombudsman help the survey offices in responding to complaints?

Mr. WHITE. They can and they do, Senator Grassley. They mediate a lot of concerns for us. Where the line is drawn is where there is some activity that is going to take some action. They do not have authority to take regulatory action, and they usually refer those

things back to us if they cannot mediate them. But they are a tremendous help to us as far as mediating concerns and complaints, and we do refer a lot of things to them.

The CHAIRMAN. Well, obviously, I thank all of you for coming. I would like to close by noting the following things. We did not hear particularly painful stories today about conditions in nursing homes, but we do hear them at forums and hearings and in letters and emails and phone calls, and we have to put it in the category of being a persistent problem. We hear about abuse, inadequate nutrition and hydration, and trouble with having complaints investigated. I hear, unfortunately, that quality care and services provided just before inspections often end when surveys are over.

The cries from residents, family members and their advocates underscore not only the critical need for us to continue to work toward improving the care of nursing home residents, but also increase the need to look at those we trust to carry out national policies to improve care to the vulnerable and frail in our nursing homes.

We know that when surveyors follow up on complaints from consumers, they find opportunities to identify problems and get them fixed. We know that nursing home staff respect the surveyors enough to put their best foot forward when the surveyors arrive, and I want everyone to know that those surveyors deserve that respect and that they can fulfill the promise of a solid enforcement system.

Unfortunately, we cannot trust the system set up by HCFA to assure us that we are getting our money's worth in this process. This hearing is part of bringing this out on the table, and obviously, we have heard some positive response from HCFA about changes already made, changes in response to the GAO, and we appreciate that follow-up.

It seems to me, however, that we cannot allow the regional offices to neglect their responsibility to oversee and evaluate the quality of the State survey agencies, and I am glad to hear that our persistent effort is paying off in the activities that you have described for us today, Mr. Hash. And I know that Rachel Block and her staff are working diligently to bring to life the Nursing Home Initiatives, and we have to express our appreciation for her and their efforts.

But there is even more to do, and it seems that unless this committee keeps up the pressure, good works go undone and good ideas go unnoticed, just as I am sure there are quality nursing homes and quality State surveyors, as Mr. White represents.

But just as I am sure that there are rotten apples in the nursing home industry, I am sure that there are still ailing branches on that tree that I described earlier, the tree of enforcement. Without a quality evaluation system, we cannot tell if those branches can be healed or if they have to be cutoff with a chainsaw so they do not hurt the rest of the tree.

No one person, no one committee, including this committee, no one HCFA department, can accomplish the enormous task of helping the rotten apples within the nursing home profession that we have identified, which are obviously a minority, but there are still problems out there. Every person has to play his or her own part,

and this includes everything we have talked about today—the surveyors, the regional office administrators, the advocates, the Congress, and the President.

We must have hope and faith in the future of our elderly as we have hope and faith in the future of our children.

So Mr. Hash, I am pleased to see from the monthly status reports that I have referred to that you have been so cooperative in sending us, that the HCFA central office staff have completed the directives, the policy changes, and the guidance for almost all of the Nursing Home Initiatives. We thank you and HCFA staff for your hard work on these initiatives. Your focus and the committee's focus now have shifted to implementing these initiatives by the HCFA regions and the States, and the GAO report today seems to indicate that so far, anyway, implementation at those levels leaves much to be desired.

So what I need now from you, Mr. Hash, is a regular report focusing on the progress being made by each region in implementing these initiatives. I am particularly interested in learning which regions might not be implementing these initiatives as they should be. So by December 1, I am going to write asking you to detail the scope and frequency of these regional reports. I want to work with you so it will not be a burden, because you can have good people in your office spending all their time working with us; on the other hand, I think that sometimes the constitutional role of congressional oversight might help you do your job somewhat better.

This committee will continue to monitor, continue to evaluate, and continue to urge HCFA to improve its effectiveness. We do not want any backsliding. We will keep at this ailing tree that I have described, the tree of enforcement, until we see all the branches burst forth with healthy new growth.

Thank you all very much. I appreciate it.

[Whereupon, at 12:11 p.m., the committee was adjourned.]

APPENDIX

STEVE WHITE RESPONSES TO SENATOR CRAIG'S QUESTIONS

Question. Isn't the fact that there is room for differences of opinion on such things as "Immediate Jeopardy" and "Actual Harm" evidence that the current survey system is vague and subjective' and therefore, inconsistencies are inevitable? If the answer is yes, then isn't it time to consider an alternative system, one which is truly objective and focused on collaboration between surveyors and providers?

Answer. Because so much of the survey process depends on the professional judgment of health care professionals and because the knowledge base in gerontology and technologies such as new medications are always changing, there will always be the potential for some variation in the survey process. A difference in opinion in the interpretation of HCFA guidance for immediate jeopardy and actual harm is only one reason for variation. Most actual harm citations, for example, are accurate citations as discussed further in response to the second question. Differences of opinion are not inevitable. A large part of the solution lies with the need for greater consistency between HCFA regional offices, a focus on improved and continuous staff training and development for both State and Federal surveyors, better communication with states and consistent, valid data that is applied uniformly from region to region in the evaluation of state performance. With HCFA definitions and guidelines, experienced professionals will more often than not reach the same determination. HCFA, in their testimony, has acknowledged that they are working to increase consistency, and we, as states look forward to working with them on this very important issue. Great deals of time, effort and training have gone into developing the current survey process. As discussed in HCFA's report to Congress, improvements in care and outcomes have resulted from the current regulations with their outcome focus. Most states would like to have more flexibility within the existing survey process, to redirect limited resources to where the problems exist, and in some circumstances work collaboratively with providers, but would not support abandoning the current survey system. Regulators need to remain regulators. They can be educators of providers, but a consultative process without an enforcement authority is not successful.

Question. OBRA '87 (Omnibus Budget Reconciliation Act of 1987) spoke of moving a survey system that focuses on resident outcomes. Yet surveyors are citing at level G, even when there is no negative resident outcome documented. Shouldn't "Actual Harm" be tied to an objective and documented negative resident outcome rather than a surveyor' subjective feeling, of whether a facility filled out the paperwork correctly of whether a facility did not follow the menu precisely?

Answer. The current survey process does focus on resident outcomes. With rare exceptions, level G deficiencies reflect actual harm to a resident. The GAO report of June, 1999, entitled "Nursing Homes: Proposal to Enhance Oversight of Poorly Performing Homes Has Merit", found that 98 percent of 107 surveys, including 201 level G deficiencies, from the ten largest states clearly documented harm to a resident or residents. As state survey agencies, we feel that this reconfirms the level of quality and consistency that does exist in the state survey process.

Question. Are there alternatives to the current survey process which should be pursued (for example, the North Dakota survey alternative process, which is outcome based)?

Answer. The survey process required by HCFA is clearly defined in statute and offers little opportunity for waivers or pilot testing of alternatives. South Dakota, for example, could not obtain a waiver from HCFA to test a quality indicator-based survey protocol, which would also have incorporated collaboration with the nursing homes. There are some studies being done in various states of ways to work differently with providers to improve care, such as the Eden Alternative, performance based reimbursement, quality improvement projects and quality incentive grants. These are being done in addition to the current survey process, not as alternatives.

Generally, states believe that the current system is resident focused and outcome oriented, and has the potential to evaluate quality of care. Insufficient resources and inconsistent oversight have resulted in a process that is less effective than it could be, but efforts should focus on improving upon the existing foundation. The availability of Quality Indicators, for example, provides an opportunity to better focus survey efforts and to evaluate facility performance in new ways through the use of new information sources.



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