HEALTH CARE FINANCING ADMINISTRATION

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REMARKS:

Business Week article — 7/1/99

7/1/99 Business Week

FINANCE

Nursing Homes: On the Sick List

These Street darlings of the '90s have been laid low

The nursing-home business, once a thriving industry, needs a good dose of intensive care. Just last year, the seven leading publicly owned companies had a market capitalization of $35 billion. Now, they're worth less than $5 billion. Some may not survive.

In the past few weeks, trading in Vencor Inc., the country's sixth-largest nursing-home operator, has been suspended by the New York Stock Exchange. One of the reasons, says the NYSE, is that Vencor's restructuring will leave its stock with "little, if any, value." The stock of the second-largest nursing-home operator, Sun Healthcare Group Inc. (SHG), will be suspended by the NYSE next week for failing to meet financial requirements. Although it has been spending money on the construction of a corporate office building, Sun recorded losses of over $700 million in 1998, precipitating significant corporate layoffs. Meanwhile, Mariner Post-Acute Network Inc. (MPN), with $2 billion in revenues, "could be headed for possible bankruptcy," according to Andrew A. Gitkin, a PaineWebber analyst. Mariner does not comment on rumors, says a spokesperson.

LOOPHOLE. The companies' stocks reflect the carnage. Most are down over 90% in the past year, with some issues trading below 75 cents. Losses for the group during the first quarter of calendar 1999 were about $160 million. Losses are expected only to get worse over the next few quarters.

How did these companies end up in such shambles? In the early 1990s, this least glamorous of industries, which represents 8% of the health-care industry, stumbled on what Wall Street saw as a bonanza. As cash-strapped hospitals began sending their sicker patients to nursing homes, operators of those facilities turned to a Medicare loophole unique to nursing homes. In effect, there were no reimbursement caps on treatments such as respiratory, physical, and occupational therapies. So when it was discovered that "rehab" or "ancillary" services could produce 30% margins, Wall Street jumped on the sector, producing a spate of initial public offerings. In 1993, right-out-of-the-box offerings were quickly trading at 20 times earnings.

In that lush environment, says Daniel E. Straus, former CEO of Multicare Cos., a chain of nursing homes sold to Genesis Health Ventures at the industry's peak, "a lot of nursing homes bet the ranch by leveraging up." Lured by the rich margins, nursing homes became hot properties.

But the timing couldn't have been worse. To cut soaring costs, Medicare instituted a new policy consisting of a daily price cap that in one fell swoop wiped out rehab margins by at least 50%. The blow to the public nursing home companies was catastrophic. "I've never seen an industry hit the wall so quickly," says Straus. The impact on the privately owned nursing homes, some 80% of the industry, appears to be much less severe. Most mom-and-pop operations and not-for-profits tended to avoid the "rehab" game.

"OBSCENE" MARGINS. Today, the public companies are busy instituting big cost cuts--but they may not come soon or deep enough. Sun, Vencor, and Mariner are scrambling to renegotiate their debt payments. But the clock is ticking. Sun defaulted on its debt in May, Vencor missed rent payments in May, and Mariner violated bank covenants during their most recent quarter. Large restructurings are expected to be announced shortly.

Industry officials blame the government, as do some on Wall Street. The government has "devastated" the nursing-home industry, says David Tepper, president of Appaloosa, a $1.5 billion value-oriented fund based in Chatam, N.J. Says another health-care analyst, who asked not to be named: "The government beat these companies up. Eventually, they will just have to hand their keys over to the government."

But some experts blame greed in the industry, complaining that rehab services were merely a device to gouge the government. "Those margins should never have existed in the first place," says Straus. "The prices they were charging were obscene and in certain instances flew in the face of the intent of Medicare's program. It abused the system."

Ironically, companies that refused to exploit the loophole were punished by Wall Street. Says Boyd W. Hendrickson, CEO of Beverly Enterprises Inc. **(BEV)**, the largest nursing-home company in the country: "We did it differently than our competitors, who indicated they would pay whatever they had to to buy a nursing-home bed in order to market ancillary products.... [People] didn't care what they had to pay." Not surprisingly, Beverly's earnings multiple was only about 12 in 1996, only about half that of its competitors.

But now, the high-priced acquisitions and other excesses are coming back to haunt the industry. And it wasn't just nursing-home operators that misstepped; even savvy Wall Streeters got burnt. Apollo Advisors, a leveraged-buyout firm, got into the market at the worse possible moment, merging three nursing-home companies within two years with a debt-to-capital ratio of over 90%.

"They made a big bet in the sector right before the sky came crashing down," says Gitkin. "They combined three companies together--two of which were very questionable... The sum of the three parts actually equalled zero."

The nursing-home game has also featured examples of lavish compensation. Take Robert N. Elkins, chief executive and founder of Integrated Health **(IHS)**, whose stock has tumbled 78% since June, 1997. That year, he made over $14 million in compensation, a Lou Gerstner-type pay package--but without the performance. Elkins still gets corporate loans to buy stock which he doesn't need to pay back if he stays on for five years. And 50% of his annual bonus is paid in advance each year. To top it off, he has a separate retirement trust to which Integrated must make "irrevocable" payments, so that by 2001 the trust will hold $23.9 million. Elkins refused to be interviewed for this article.

"Integrated looks like a company out of control," says compensation expert Alan Johnson, managing director of Johnson Associates Inc. in New York. "The company's financial problems, he helped create. It seemed like he tried to find every conceivable way to figure out how to pay

himself."

Not all nursing-home companies have such bleak stories. Those that stayed away from towering leverage and the rehab businesses, such as HCR Manor Care Inc. (HCR) and Beverly, are in the best shape today. But the going will be tough for the others. "The government has basically eliminated the get-quick-rich games," says Andre C. Demitriadis, CEO of LTC Properties Inc. (LTC), a health-care real estate trust.

But there could be a ray of relief after this generally sorry story. The reason: demographics. The cohorts of individuals 65 and older are expected to grow to 79 million by the year 2050, compared to about 34 million today.

STILL A VALUE? Some nursing-home investors are now poised to help revitalize the industry. Joseph K. Piper, a partner with Seattle-based venture-capital fund Integra Bio-Health, which specializes in investments in the health-care industry, sees a new chapter for nursing homes.

"We're looking for entrepreneurs who have a fresh view of how nursing-home services can be provided," says Piper. He hopes to create nursing homes that are smaller and homier. And through better technology, operators will spend less time on paper work and more time with patients. "For the dollar spent, nursing homes are still a very good value," says Piper. "It's a fantastic industry," adds Straus.

Maybe. But meanwhile, the industry needs a heavy dose of rehab.
By Debra Sparks in New York

FINANCE

Intensive Care?

Most of the publicly owned nursing-home stocks have taken big hits

	STOCK PRICE (6/22/99)	DECLINE FROM 6/22/97	
VENCOR	19 cents	-99%	Overpaid for two acquisitions
SUN HEALTHCARE	34 cents	-98	Expanded at the wrong time
MARINER POST-ACUTE	56 cents	-96	A collection of three ailing companies
GENESIS HEALTH VENTURES	$4.31	-86	Ill-timed acquisitions

HEALTH CARE FINANCING ADMINISTRATION

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~~Business Week~~ article — 7/1/99

Another one - Wall St. Journal

6/30/99

WSJ B4 6.30.99

Sun Healthcare's Critics Cite Acquisitions and Decisions

Medicare Reimbursement Changes Get Firm's Blame for Its Default, Red Ink

By J.C. Conklin
Staff Reporter of The Wall Street Journal

Sun Healthcare Group Inc., in default on $1.57 billion in bank debt, is swimming in red ink. The once-soaring nursing-home company blames recent cuts in Medicare reimbursements.

But analysts and industry insiders say that isn't the whole story.

An aggressive acquisition binge that led to a heavy debt load, a bad bet on which services to provide and a failure to react quickly when times turned tough all contributed to the chain's woes, analysts say. "With their balance sheet, everything would have had to go perfect for them to succeed," said Jean L. Swenson, an analyst at Deutsche Banc Alex. Brown.

To be sure, changes in Medicare have compounded Sun's problems. Under a that began last year, nursing-home operators are paid based on a fixed rate rather than reimbursed for the actual cost of their services. Based on a pilot program it ran on one of its homes, Sun estimated that the new program would cut its revenue by 18%.

Instead, the reduction was more like 30%—in part because the Albuquerque, N.M., company didn't know how key services like respiratory therapy would be reimbursed. Yesterday's proposals by the Clinton administration to curb some Medicare reimbursements could compound Sun's troubles.

Net Loss Posted

In the first quarter, Sun said, revenue 9.2% to $673 million. The company posted a $113.2 million net loss after write-downs and charges. Its stock, which has been suspended from trading, last sold at about 25 cents a share, down from a 52-week high of $18.125 last July on the New York Stock Exchange.

Other nursing-home operators, such as Beverly Enterprises Inc., have managed to avoid such pain. In Beverly's case, pressure from shareholders to im- its price a ago

Nursing-home chain	June 1998	$211.8
German long-term-care facility operator	January 1998	15.1
Australian hospital chain	November 1997	16.8
Nursing-home chain	October 1997	367.0
Respiratory therapy provider	October 1997	16.8
Spanish nursing-home operator	July 1997	12.0
Nursing-home chain	February 1997	12.0

prompted it to sell a string of units, including a chain of acute-care hospitals. Beverly, Fort Smith, Ark., paid down $325 million in debt.

Analysts say Sun's problems built up over a number of years. Under its risk-taking chairman and chief executive officer, Andrew L. Turner, Sun grew from a start-up to the nation's second-largest nursing-home chain in a decade. Mr. Turner, who declined to be interviewed and who some analysts say is as hard to get hold of as President Clinton, led a buying spree in which the chain gobbled up 389 nursing homes, giving it an impressive debt load and the nickname Pac Man.

Sun's last large acquisition, of Retirement Care Associates Inc., a chain of 110 homes, started to turn sour almost right away. Sun acquired RCA in June 1998 after lowering the acquisition price by $40 million to $211.8 million—after RCA's independent accountant resigned and the company restated its 1996 results. Shortly after Sun acquired RCA, the state of Florida sued the Atlanta concern, alleging Medicaid fraud and patient abuse.

To make matters worse, the Medicare reimbursement changes started at RCA six months sooner than Sun expected. In March, Sun sued RCA's former management in Georgia state court accusing the executives of "the illicit transfer" of funds into another company the executives operated. Those executives have filed a defense denying any liability.

"RCA was a mistake," said Robert M. Mains, a health-care analyst for Advest Inc. in Saratoga Springs, N.Y.

Robert D. Wollil, Sun's chief financial officer, says: "RCA was, by most accounts, a difficult acquisition. The timing was not particularly good."

Sun also made a strategic decision in the mid-1990s to move into high-margin services, such as speech and respiratory therapy, in response to insurers' pressure to make patients leave hospitals sooner. Those services depended heavily on Medicare reimbursements, which at the time had few restrictions on how much therapy could be given and the cost.

Last year, many companies, anticipating the Medicare changes, started diversifying by moving into lower-margin, but faster-growing, businesses such as assisted-living facilities. But Sun didn't and was hurt when Medicare reimbursements for specialty services fell b 15% and 20%. In 1998, Sun's rehabilitation and respiratory therapy unit accounted for about 22% of Sun's revenue. In the first quarter of this year, it dropped to 11%. Almost 100 of the nearly 1,300 outside nursing homes that used Sun's services have dropped them since March 1998.

"Sun gambled and lost," said Bruce Broussard, a former Sun chief financial officer who founded another company. "They didn't think the changes in Medicare would be as great as they are."

In response, Sun said in April it would increase the number of employees it would eliminate to 10,000 out of 80,000. Yet some Sun watchers are peeved that Mr. Turner has continued construction of a $65 million expansion of company headquarters. To make matters worse, Sun doesn't have a lot it can sell to reduce debt. Most of its nursing homes are already leveraged or leased from others. Because of reimbursement changes, its once-valuable ventilator and therapy services divisions aren't worth much.

Canadian Sale

The company recently sold its Canadian outpatient rehabilitation clinics for about $8 million. It is currently trying to sell its assisted-living facilities and rehabilitation hospitals.

Sun is still negotiating with its banks and other debtholders. If an agreement can't be reached, it faces the possibility of seeking protection from creditors under bankruptcy laws.

Still, Sun doesn't plan on changing its strategy to focus on lower-margin services. "We've cut costs significantly, shown improvement month over month," said Mark Wimer, Sun's president and chief operating officer. Further, he said, many states are talking about making substantial increases in their Medicaid programs, a move that should benefit Sun.

Noting that the Medicare changes have been in full effect just a few months, Mr. Wimer said, "You don't make a major change in long-term strategy after three months."

New Jersey Association of Health Care Facilities

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HAMILTON, NEW JERSEY 08690-1740

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FAX 609-584-1047

June 18, 1999

Chris Jennings
Deputy Assistant to the President
for Health Policy
The White House
1600 Pennsylvania Avenue, NW
Washington, DC 20500

Dear Mr. Jennings:

Just a short note to tell you how much I enjoyed listening to your remarks at the American Health Care Association's Executive Board meeting on June 8, 1999. While I may not agree with everything you said, I greatly appreciate your candor and the very positive and constructive tone of your remarks.

As you may recall, I brought to your attention HCFA's Abuse Awareness Pilot Program. I have attached another copy of the poster that local Ombudsman Programs will be asking nursing facilities to post beginning in early July. I firmed believe that this program sends the wrong message to providers, their employees and, most importantly, the residents and families that they serve. It is not constructive, is very "stereotypish" and is very adversarial. **Once again, I ask that the Administration direct HCFA to stop the Program.**

Thank you for your consideration.

Respectfully,

William R. Abrams
President


Sometimes
ABUSE
is not so
obvious
HCFA
We need your help to
spot abuse in nursing
homes and report it.
The Health Care Financing Administration, a part of the federal government, your nursing home administrator and your local state agencies will not tolerate abuse.
To report abuse, contact:
ENFORCEMENT
EMPOWERMENT
EDUCATION
HCFA Nursing Home Initiative

FAX

Date 5/27/99

Number of pages including cover sheet 10

TO: CHRIS JENNING

Phone

Fax Phone 456-5557

FROM: John Schaeffler, Di
of Congressional A
American Health C
Association
1201 L Street NW
Washington DC 20

Phone (202)-898-2808

Fax Phone (202)-842-3860

CC:

REMARKS: ☐ Urgent ☐ For your review ☐ Reply ASAP ☐ Please Co

Dear Mr. President:

We are writing to express our shared concern regarding the impact of the Balanced Budget Act (BBA), and its proposed implementing regulations, on our nation's nursing homes and the Medicare beneficiaries they serve.

Unfortunately, it was impossible to foresee all the possible unintended effects implementation of the BBA would have on particular categories of care available to Medicare beneficiaries.

We believe the growing crisis in the nursing home industry stems, in part, from the implementation of the BBA. If steps are not taken to improve reimbursement during the transition to a prospective payment system (PSS) for skilled nursing facilities, we fear that dedicated care-givers may be laid off, facilities may close, access may be reduced, and quality may decline. This clearly is not what was intended when the BBA passed.

The Administration has the ability to address some of these concerns by revising its regulations that currently may be contributing to the problem, and by making every effort to ensure that the transition to a prospective payment system does not ultimately harm patients. We would like to work with you to address this matter in whatever manner is appropriate.

Sincerely,

Double/
Gephart
will sign

450-5657

United States Senate

WASHINGTON, DC 20510

May 19, 1999

The Honorable Donna Shalala
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Madame Secretary:

We are writing to express our deep concerns about the growing crisis in the nursing home industry. We are concerned that payment rates for Skilled Nursing Facilities (SNFs) are well below the levels envisioned by Congress, and this reduction in payments could seriously erode the quality of care available to our seniors.

The Balanced Budget Act of 1997 (BBA) has produced a number of positive results. We have a balanced budget, and Medicare's solvency has been extended by many years.

However, it should not come as a surprise that implementing complex legislation such as the Medicare provisions in the BBA is producing some unexpected and undesirable consequences in certain sectors

In particular, we believe that the regulations implementing the SNF payment changes may reduce rates substantially more than was intended and projected at the time of enactment. If HCFA does not revise the regulations, we fear we will soon see closings of facilities, layoffs of dedicated care-givers, reductions in access to SNF services, and erosion in the quality of care.

We urge you to use your authority to revisit the regulations to ensure the transition to the new prospective payment system (PPS) does not harm beneficiaries with unnecessary reductions in payment rates that go beyond what any of us anticipated. In particular, we would urge you to revise the regulations to reflect the needs of medically complex patients, particularly their need for non-therapy ancillary services.

We know you share our commitment to ensuring that elderly and disabled Medicare beneficiaries receive the highest quality care. We would like to work with you in a bipartisan fashion to address this impending crisis in whatever manner is appropriate.

Sincerely,

Pete V. Domenici

Jeff Bingaman

D

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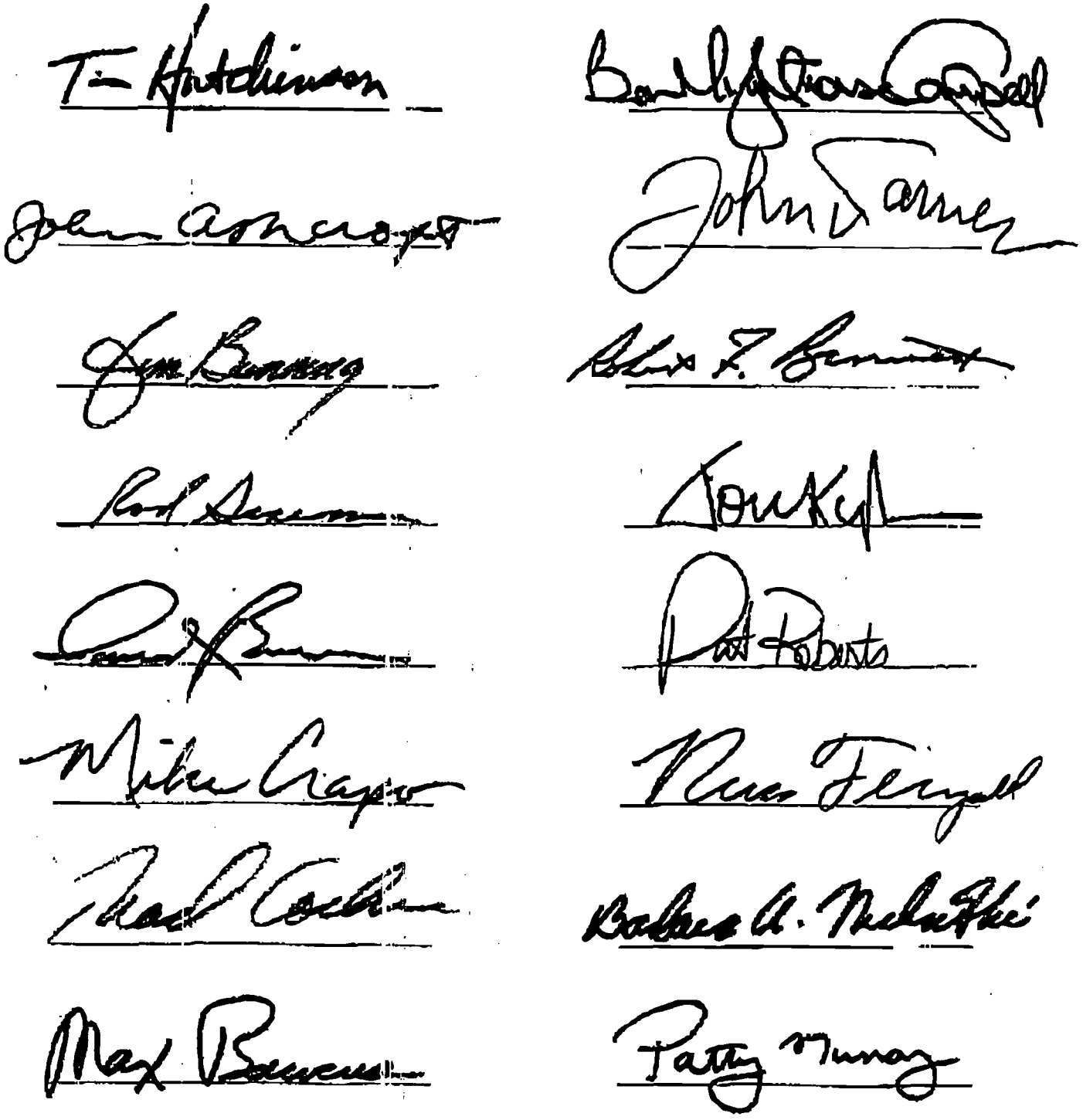
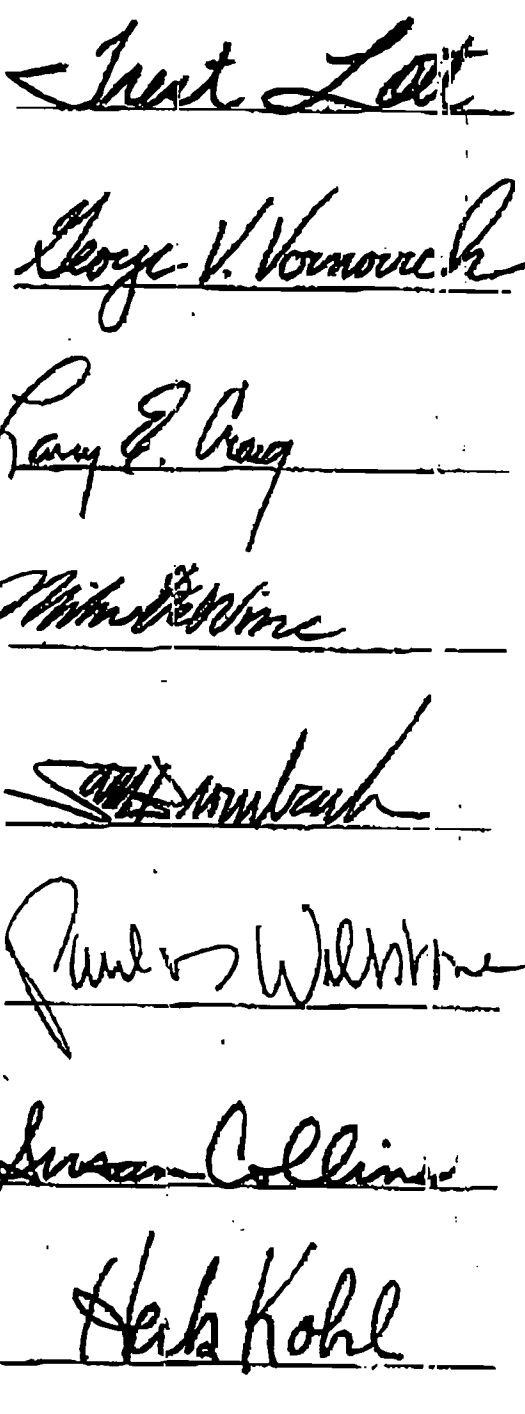
D

D

SNF RS





John McCain

Barbara Boxer

Kyl	Johnson
Coverdell	Kohl
Craig	Boxer
Voinovich	
DeWine	
Collins	
Sessions	
Brownback	
Shelby	
Chafee	
Lugar	
McCain	

Republican	Democrat
Domenici	Bingaman
Bunning	J. Kerrey
Bennett	Wyden
Burns	Durbin
Grams	Cleland
Crapo	Landrieu
Campbell	Sarbanes
Cochran	Reid
Warner	Lautenberg
Roberts	Levin
Hutchinson	Dorgan
Santorum	R. Kerry
McConnell	Daschle
Frist	Lincoln
Specter	Hollings
Lott	Robb
Jeffords	Torricelli
G. Smith	Murray
Hatch	Conrad
Hagel	Feingold
Gorton	Mikulski
Abraham	Kennedy
Ashcroft	Baucus
Bond	Wellstone

- The Secretary must publish in the Federal Register, on or before August 1 of each fiscal year (beginning with fiscal year 2001), the classification and weighting factors for case mix group, and a description of the data and methodology used in computing the prospective payment rates.

- There is to be no administrative or judicial review for the establishment of the case mix groups, the prospective payment rates, outlier and special payments, or the area wage adjustments.

Effective Date

- For cost reporting periods beginning on or after October 1, 2000, except that the Secretary may require submission of data on or after the date of enactment.

Development of Proposal on Payments for Long-Term Care Hospitals (Section 4422)

Provision

- Requires the Secretary to develop a legislative proposal for establishing a case-mix adjusted PPS for payment of long-term care hospitals. The Secretary is authorized to collect data from long-term care hospitals, and must submit a report to Congress detailing the proposed system.

Effective Date

- Upon enactment. The report to Congress is due not later than October 1, 1999.

SUBTITLE E--PROVISIONS RELATING TO PART A ONLY

Chapter 3--Payment for Skilled Nursing Facilities

Extension of Cost Limits (Section 4431)

Provision

- SNF routine cost limits would be based on the limits that were in effect for the previous year.

Effective Date

- For cost reporting periods beginning on or after October 1, 1997.

Prospective Payment for SNF Services (Section 4432)

Provisions

- o Phases-in a prospective payment system (PPS) for skilled nursing facility (SNF) care that would pay a Federal per diem rate for SNF services. The per diem payment would cover routine, ancillary, and capital-related costs. Covered services include all items and services (other than those specifically exempted) for which payment may be made under Part B and which are furnished to an individual who is a resident of a SNF during the period in which the individual is provided covered post-hospital extended care services.

- o The PPS has a 3 year phase-in period. During this period, payment is the sum of the non-Federal percentage of the facility-specific per diem and the Federal percentage of the adjusted Federal per diem rate. The payment blend is as follows:

  + For the first cost-reporting period, the non-Federal percentage is 75% and the Federal is 25%. In the second cost-reporting period, the non-Federal percentage is 50%, and the Federal is 50%. In the third cost-reporting period, the non-Federal percentage is 25% and the Federal is 75%.

- o The calculation of the Federal and facility-specific rates are based on allowable ~~costs~~ for cost reporting periods beginning in fiscal year 1995.

  + The facility-specific base payment is determined by estimating , on a per diem basis, the total of the allowable costs of services in FY 1995 (with adjustments for non-settled cost reports) and an estimate of the amounts that would have been payable under Part B for certain services. The Secretary will take into account exception payments. The Secretary will also take into account exemptions, but only to the extent that routine costs do not exceed 150% of routine costs otherwise applicable but for the exemption. This base payment amount will be updated to the first cost-reporting period by the market basket minus 1 percentage point.

    During FY 1998-1999, this amount will be updated by the SNF market basket minus 1. During each subsequent fiscal year, the update is equal to the market basket increase for such fiscal year. Facilities involved in the Nursing Home Case-Mix and Quality Demonstration will receive the 1997 RUGS-III rate.

  + The historical Federal per diem rate is calculated (for each SNF subject to the per diem) by estimating, on a per diem basis, the total of 1995 allowable costs (not exempted from the limits) plus an estimate of the amounts that would be payable under Part B. This amount will be updated to the first cost-reporting period by the

market basket minus 1 (on an annualized basis).

+ The unadjusted Federal per diem rate beginning on July 1, 1998 and ending on September 30, 1999 equals the average of the weighted average per diem for all facilities, and a weighted average per diem for freestanding facilities. This amount will be increased by the MB minus 1 percentage point.

  -- For FY 2000, this rate will be increased by the SNF MB minus 1 percentage point.

  -- For FYs 2001 and 2002, the rate of the previous fiscal year will be updated by the MB minus 1 percentage point.

  -- For each subsequent fiscal year, the update is the MB.

+ The unadjusted Federal per diem will be adjusted for case mix, case-mix creep, and for geographic variations in labor costs.

o For each fiscal year, the Secretary is required to publish in the Federal Register, prior to August 1, the unadjusted Federal per diem rates, the case-mix classification system, and the factors to be applied in making the area wage adjustments.

o Requires payment for all Part B items and services to be made to the facility (consolidated billing). Consolidated billing requirements apply to Medicare beneficiaries residing in SNFs or facilities of which only a distinct part is a SNF. Payments for Part B services would be based on existing fee schedules established by the Secretary. A uniform coding system will be specified by the Secretary that identifies items and services furnished. Facility provider numbers are required on claims submitted by physicians.

o There will be no administrative or judicial review of: (1) Federal per diem rates, including adjustments or corrections for case mix and adjustments for variations in labor-related costs; (2) facility-specific rates; or (3) the establishment of transitional amounts.

o Requires the Secretary to develop an appropriate transition for swing-bed hospitals.

o Each SNF is required to submit resident assessment data necessary to develop the rates under this subsection using the resident assessment data instrument.

o The Secretary must establish a medical review process to examine the effects of the PPS on the quality of services. Particular emphasis is to be placed on non-routine covered services and physician services.

Effective Date

- Applies to cost-reporting periods beginning on or after July 1, 1998. Consolidated billing applies to all items and services furnished on or after July 1, 1998.

SUBTITLE E--PROVISIONS RELATING TO PART A ONLY

Chapter 4--Provisions Related to Hospice Services

Payments for Hospice Services (Section 4441)

Provision

- The hospice prospective payment rates will be updated by the hospital market basket minus 1 percentage point for each of the fiscal years 1998 through 2002. In addition, the hospices will be required to submit such data as the Secretary requires on the costs of the care they provide for each fiscal year beginning with fiscal year 1999.

Effective Date

- Noted above.

Payment for Home Hospice Care Based on Location of Service (Section 4442)

Provision

- Hospice services will be paid based on the location where the service is provided, rather than where the service is billed (typically the urban location of the hospice agency.

Effective Date

- Effective for cost reporting periods beginning on or after October 1, 1997.

Hospice Care Benefits Period (Section 4443)

Provision

- Restructures the hospice benefit periods to include two 90-day periods, followed by an unlimited number of 60-day periods. The medical director or physician member of the hospice interdisciplinary team would have to re-certify that the beneficiary is terminally ill at the beginning of the 60-day periods.

Effective Date

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Center for Medicaid and State Operations
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear State Medicaid Director:

As part of our efforts to strengthen nursing home enforcement and improve the quality of care for residents, we also want to continue to ensure beneficiaries have alternatives to nursing home care if that is their choice. Since the early 1980's, the Home and Community Based Waiver Service (HCBWS) program and personal care options have been used successfully by States to provide beneficiaries with alternatives to nursing home care and to help people move out of nursing homes into the community. With further developments in community supports and technological advances, there is an increased opportunity for individuals at many levels of disability to be safely served in the community. In light of this, we believe a real need exists to continue to work with States to help more people become aware of choices available to them in the community and transition out of nursing homes if that is their choice.

The Health Care Financing Administration (HCFA) in association with the Assistant Secretary for Planning and Evaluation, is interested in working collaboratively with States to enhance choices available to Medicaid beneficiaries who are currently residing in nursing homes. Therefore, a new grants initiative is being sponsored to assist States in developing processes and infra-structure changes for the purpose of transitioning these individuals out of nursing homes into the community. States are encouraged to incorporate community-based attendant care services which ensure maximum control by the beneficiary to select and manage their attendant care services.

HCFA will award four to six grants under this initiative. The enclosed grants announcement provides information regarding general policy considerations, special areas of interest, application procedures, eligibility requirements, and review criteria. **As identified in the announcement, the deadline for submitting an application is July 27, 1999. Proposals must be postmarked on or before this date and received in the HCFA grants office.**

Grant funds may be used either to assist awardees in developmental activities or to fund transitional services not otherwise funded under the Medicaid program. Grant awards of up to $500,000 will be available to applicants selected to participate in this project. These awards are intended to cover a developmental period which would

generally be up to 15 months. It is important to note that the grants are special project funds which do not require State matching funds. Accordingly, States which are awarded grants will not report the grant amount on the HCFA-64 expenditure report. Rather these funds will be reported on the Financial Status Report, SF269A.

If you have any questions regarding this grant announcement, please call Mary Jean Duckett, Director, Division of Benefits, Coverage, and Payment; Disabled and Elderly Health Programs Group at (410) 786-3294.

We look forward to receiving your application.

Sincerely,

Sally K. Richardson
Director

Enclosure

cc: Federal Partners
Constituency Partners
All HCFA Regional Administrators
All HCFA Associate Regional Administrators
for Medicaid and State Operations
Lee Partridge
American Public Welfare Association
Joy Wilson
National Conference of State Legislatures
Matt Salo
National Governors Association

NURSING HOME TRANSITION INITIATIVE

Sponsored By
The Health Care Financing Administration

I. Purpose

The Health Care Financing Administration (HCFA) is soliciting proposals from States to assist current nursing home residents who choose to live in the community to move to home and community based settings, to safely remain there and to maximize their participation in community life. While many States have developed procedures for diverting prospective nursing home residents from institutions, far fewer States have attempted to design programs to assist nursing home residents to return to the community. The Nursing Home Transition Initiative will provide administrative and service resources to States to develop such programs. HCFA will award grants to up to six State Medicaid agencies under this initiative, executed as cooperative agreements. The Assistant Secretary for Planning and Evaluation (ASPE) intends to conduct an evaluation of successful grantees to assess effective practices and associated costs.

HCFA encourages States which are just beginning to develop their capacity to provide home and community based services to apply for this solicitation, in addition to States which have already put into place more comprehensive systems of home and community based services.

II. Background and Goals

Both President Clinton and Secretary Shalala have expressed their interest in and commitment to expanding access to home and community based services for people with disabilities of all ages. Although many States have moved aggressively to expand access to home and community-based waiver services (HCBWS) as alternatives to nursing home care, the emphasis has been on deterring nursing home admissions, far fewer States have made the transition of nursing home residents to the community a major component of their long-term care program. There is evidence that this is changing. Twenty States applied for the "Date Certain" grants announcement released by HCFA in 1998 to help divert and relocate current nursing home residents into the community and four States received awards– Colorado, Michigan, Rhode Island, and Texas .

This solicitation builds upon the FY 1998 Date Certain Grant initiative by making up to $2,000,000 additional dollars available to States to:

- identify nursing home residents who wish to return to the community and educate them and their families about the alternatives available to them ;

- overcome the resistance and the barriers which may be in the way of their exercising this choice; and

- develop the necessary infrastructure and supports in the community to permit former nursing home residents to live safely and with dignity in their own homes and communities.

Funds made available under this new grant program can be used for a broad range of purposes identified by program officials, the nursing home resident and their families to permit a successful transition to the community. For example, grant funds may be used to cover "transitional costs" which are traditionally not covered under the HCBWS program or are not included in the state plan such as temporary rent payments, furniture and clothing, special equipment or direct cash payments to the individual with a disability and or their families to insure that necessary services are available. States are encouraged to develop mechanisms which would make it easier for beneficiaries to select and supervise their community-based attendant care, if in the judgment of program officials they (or their surrogate) are able to direct their own care.

We also note that although the focus and funding under this new grant initiative is solely for supporting the transition of current nursing home residents to the community, States are encouraged to continue to independently explore and develop single point of entry/pre-admission screening processes for the purpose of diverting beneficiaries from nursing homes.

III. The Initiative

The purpose of the Nursing Home Transition Initiative is to provide States with administrative or services resources to enhance opportunities for nursing home residents to move into the community. Grant awards of up to $500,000 will be available to States selected to participate in this project. Grant funds can be used for administrative tasks such as program development or consulting or for reimbursement of direct services not otherwise reimbursed by Medicaid under the State plan. Since the type and extent of barriers to community placement varies among the States, grant funds are intended to provide for as much flexibility as possible. States may propose whatever combinations of direct service and administrative funds that meet their needs.

There is no limitation on the age of an individual who may be served nor a restriction on the medical condition of the individual as long as his/her health and welfare in the community can be safeguarded. There is no restriction on the number of persons to be served provided that, if a waiver of federal statutory requirements is needed, all applicable cost-effectiveness, cost-neutrality, or budget neutrality demonstrations are met. The following are areas which have been identified as particularly critical in the successful transition of nursing home residents to home and community based settings. Successful applicants are expected in their proposal to address many or all of these areas.

Identifying Nursing Home Residents who are Potential Candidates for Transition to the

Community

With the advent of many innovative technologies and assistive devices and the availability of funding for services not otherwise traditionally covered under Medicaid, successful community support systems can be developed for a wide range of individuals. A major challenge facing States in developing a successful nursing home transition program is designing and implementing feasible and effective processes for identifying individuals in nursing homes who look like good candidates for community living. The use of statewide data sources such as minimum data set (MDS) or other assessments to help States in identifying potential candidates is encouraged. Nursing home ombudsmen, independent living centers, protection and advocacy organizations and other local groups and programs may also be of assistance in many States..

Improving Communications

An important element of a nursing home transition program is educating individuals residing in nursing homes about their options. These individuals, their families, and legal guardians may not be an easy population to reach. States should consider how they will gain access to nursing facilities to contact these individuals. They should also consider the importance of educating families and surrogates about community placement options including the safeguards to be employed by the State to ensure health and safety of their family members and the State's commitment beyond the life of the initiative to support community living options. Of central importance is the role played by the state in promoting the program, including working with nursing homes so that they understand project goals and cooperate with the project, developing mechanisms for gaining access to nursing homes and talking to potential candidates for the project and their families about their options, and ensuring informed choice.

Developing Community-Based Services/Supports for Institutionalized

One of the primary goals of this grant initiative is to establish viable community support systems and a comprehensive set of choices for beneficiaries currently residing in nursing facilities so that they can live safely, maintain and improve their health status, and participate in community life to the extent they desire and are able. States need to consider the range of services and supports that will enable people with all levels of disability, including significant disability, to meet the above goals and identify and eliminate barriers which may impede success. Of particular importance is ensuring the availability of appropriate housing options.

Sometimes barriers to effective transition may be found in State regulations and policies or in the organization of the provider network. For example, there may be no provision for nighttime services, assistive technology may be difficult to obtain or there may be no training available in how to use it. Alternatively, there may be gaps in the supply of quality providers such as attendants or transportation services or a lack of opportunities for people with disabilities to direct their own services. As part of the solicitation, States are encouraged to explore ways of developing a network of

community-based providers, fostering informal supports, and creating housing opportunities for those nursing home residents who will participate in the nursing home transition program.

Coordinating Efforts with Nursing Facilities

States may also need to consider the effect of transitioning persons out of a nursing facility on the nursing facility's operation so that this does not become a barrier to an individual's transition to the community. States may want to explore alternative ways in which nursing facilities can utilize their facility to support community based programs.

Developing Innovative Funding Arrangements

Another barrier to the use of home and community-based services is the fragmentation of home and community based funds to several different State agencies. Thus, even when home and community-based services are less expensive than nursing home care, it is often difficult for an individual to choose community-based care or to transition to community-based care because of a lack of coordinated funding. States are encouraged to explore and develop flexible funding arrangements which would allow funding to shift from institutional care to home and community-based care, thereby enabling adequate funding to follow the individual.

Monitoring and Safeguarding the Transition Population

Once an individual is settled in the community, States need to consider how to ensure that needs continue to be met, problems are resolved and that as circumstances change, there is a life line for the individual to call upon. States should consider the variety of safeguards that ought to be in place, particularly in the first year of the person's return to the community, to ensure that his or her progress is monitored and appropriate intervention is available as is warranted by the person's individual circumstance. The state may wish to call upon advocacy groups and consumers to help monitor or develop the mechanisms to monitor the quality of the State's program and provide a feedback loop to the State on issues which need to be addressed and on how to improve the program.

Partnering with Beneficiaries, Families, Advocacy Groups, and Providers

The success of the nursing home transition program will be enhanced by the development of partnerships. Partnerships can be with the consumer, the consumer's family and significant others, advocacy groups, Centers for Independent Living, the State Housing Authority, other State agencies, and the State legislature. These partners can join with the State Medicaid agency to develop the State's demonstration program, identify needed infrastructure, and design the care system. Advocacy groups and consumers can be used to educate case managers about the consumer's needs/desires. States are encouraged to address the use of partnerships in their proposals.

IV. General Provisions

Although applicants have considerable flexibility in developing demonstration projects under this solicitation, the project must comply with the following:

Duration of Proposed Program
States applying for a grant should plan to expend grant budgets in a period of no more than fifteen months from the date of the award.

Waiver Authority
There are a variety of benefit combinations, utilizing for example any one of the waiver authorities at section 1915(b), 1915(c), 1915(d) or 1115 of the Social Security Act, that a State could put together as part of its proposal under this grant initiative. A State, however, is *not* required to submit an application for any of these waiver programs as part of its grant proposal; but may choose to do so if it is necessary to waive a Federal statutory requirement which prevents the State from, for example, developing innovative funding arrangements or eliminating barriers to the use of community-based care. Waivers will be granted after the appropriate review if they are determined necessary by the Department. Moreover, all applicable required demonstrations of cost-effectiveness, cost-neutrality, or budget neutrality remain in effect should any of the above noted waiver authorities be sought under this grant initiative.

Budget Neutrality
Budget neutrality requirements differ depending on the Medicaid waiver authority necessary to conduct the demonstration. The budget neutrality standard for a Medicaid 1115 demonstration waiver is the most stringent one, but states must comply with the cost-effectiveness or cost-neutrality requirements for any other type of waiver they are granted. The Medicaid 1115 waiver requires that federal Medicaid expenditures must not be higher than they would have been in the absence of the waiver. If waivers are necessary, the Departmental review team will provide assistance to State grantees to explain and assist with the budget neutrality, cost-effectiveness or cost-neutrality requirements, whichever is applicable, for the various waivers.

Independent Evaluation
All grantees receiving awards under this grant program must agree to participate in an independent evaluation of the program's effectiveness. Grantees agree to provide health status, expenditure, utilization, outcome and additional data as appropriate to support the evaluation. States may be required to submit case studies of persons participating in the transition project.

Choice of Services
Election of home and community-based alternatives must be at the choice of the consumer (or the legal guardian acting on the consumer's behalf).

Civil Rights
All grantees receiving awards under this grant program must meet the requirements of

Title VI of the Civil Rights Act of 1964; Section 504 of the Rehabilitation Act of 1973; the Age Discrimination Act of 1975; Hill-Burton Community Service nondiscrimination provisions; and Title II, Subtitle A, of the Americans with Disabilities Act of 1990.
States are encouraged to contact the Office of Civil Rights, DHHS at (202) 619-0403 for technical assistance in developing a grant proposal that meets all the requirements of the civil rights and disability laws.

V. Applying For A Grant

Eligible Applicants
Applicants eligible to apply for grant funding must be State Medicaid agencies. State Medicaid agencies are encouraged to work with consumers and their families, other State agencies, community organizations, providers, and other entities in developing applications.

Proposal Format
Appendix One contains a format for submitting a proposal.

Deadline for Submission
The closing date for proposals submitted under this solicitation is July 27, 1999. A proposal will be considered on time if it is postmarked on or before this date and received in HCFA grant's office. Proposals must be mailed through the U.S. Postal Service or a commercial delivery service. A proposal postmarked after the closing date will be considered late. Late proposals will not be considered for an award.

An original proposal should be sent with **fifteen copies** to:

Attn: Ms. Marilyn Lewis-Taylor
Health Care Financing Administration
OICS, AGG, Grants Management Staff
C2-21-15
7500 Security Boulevard
Baltimore, Maryland 21244-1850
Phone : (410) 786-5701

VI. Application Review

An independent review will be conducted by panels of experts. The panelists' recommendations will contain numerical ratings (based on the criteria specified in Appendix Two), the ranking of all applicants, and a written assessment for each proposal. The recommendations of the panel will be reviewed by HCFA and ASPE. HCFA reserves the right to conduct site visits to those States receiving the highest ratings from the technical review panel. The number of States who may receive site visits will be determined based on the number of submissions and the number of proposals scored as technically acceptable by the technical review panel.

Final award decisions will be made by the HCFA Administrator after consideration of the comments and recommendations of the technical review panelists, comments and recommendations of the site visit teams (if conducted), and availability of funds.

Awards will be made by September 30, 1999. States will receive written notification of the final award decision. We expect to announce award decisions in September 1999.

VII. Additional Information

For additional information regarding this solicitation, please contact:

Mary Jean Duckett
Director, Division of Benefits, Coverage and Payment
Disabled and Elderly Health Programs Group
Center for Medicaid and State Operations
S2-11-07
7500 Security Boulevard
Baltimore, Maryland 21244-1850
(410) 786-3294

Appendix One

Application Guidelines

The following guidelines are intended to assist States in preparing application for funding under the Nursing Home Transition Initiative.

- The narrative portion of the proposal should not exceed 40 double-spaced typewritten pages.
- Additional documentation may be appended; however, material should be limited to information relevant to the specific scope and purpose of the grant. Please do not include critical details in an Appendix.

Recommended Proposal Format

A complete proposal consists of a narrative application plus the required material noted below. Application materials should he organized as follows:

1. Governor's Designation Letter

A letter from the Governor identifying the lead organization and affirming that it is responsible for overseeing the planning and development of the state's proposed initiative. The letter should indicate that the lead organization has clear authority to oversee and coordinate the proposed activities and is either a representative of, or, is charged with convening a suitable interagency working group of all relevant state agencies.

2. Cover Letter From Medicaid Director

A cover letter signed by an authorized individual on behalf of the lead organization. The letter should indicate the title of the project, the name of the lead organization and principal contact person, the amount of funding requested, the amount of state matching funds committed for the planning phase, and the names of all organizations collaborating in the effort.

3. Project Abstract

A project abstract limited to one page. The abstract should serve as a succinct description of the proposed project and should include:

- The overall goals of the project.
- A description of the proposed target population, covered benefits, and reimbursement methodology.

4. Narrative Application

The narrative application should provide a concise and complete description of the proposed project. The narrative or body of the application must not exceed 40 double-spaced pages plus the one page abstract noted above. Please do not rely on appendices to describe key details. This narrative should contain the information necessary for reviewers to understand fully the project being proposed and should be organized as follows:

A. Provide a description of the state's current home and community based care systems for Medicaid clients and the status of Medicaid pre-admission screening and nursing home reimbursement systems. Please include the following:

- The number and kinds of Medicaid clients already enrolled in Medicaid home and community care program (waivers and personal care). The plans for expansion and the status of pending waiver applications.
- The availability of data (especially functional status) on nursing home residents and persons in home and community based waivers.
- An overall assessment of the strengths and weaknesses of the state's home and community based care infrastructure.
- Expected results and system reforms.

B. Provide a description of the nursing home transition program that the state is planning to develop. While planning for many of the areas may be incomplete, please include as much detail about the following proposed components as possible:

- **Target Population**

  Identify the target population for the nursing home transition program. The estimated number of persons to be moved from nursing homes to the community must be included accompanied by an explanation of how this figure was reached. **APPLICATIONS NOT INCLUDING AN ESTIMATE OF THE NUMBER OF PERSONS TO BE OFFERED THE CHOICE OF COMMUNITY LIVING UNDER THIS ANNOUNCEMENT WILL BE CONSIDERED**

NON-RESPONSIVE AND WILL NOT BE CONSIDERED FOR FUNDING..

The discussion of the target population should include the following:

- potential data sources to be used to identify program candidates.
- geographic location of target population; and,
- estimated number of nursing homes from which program candidates will be drawn.

· **Services to be Made Available**

Describe the continuum of services including consumer-directed services that are expected to be made available to the transition population. The use of direct services grant funding and or other innovative financing or housing programs should also be discussed. The application should make clear the services that are currently available, proposed additional services funded by Medicaid, and proposed additional services funded by the direct services portion of the grant. Also included in this section are services from other agencies that are part of the continuum of services necessary to support disabled persons in the community. For example, States may want to consider advocacy services to ensure that the interests of the transition population are protected during and after a move back into the community, and strategies for working collaboratively with nursing homes.

· **Communication / Access Plan**

Discuss the States thinking with respect to how they will inform residents and their families and care givers about the program. State should also describe how they will gain entrance to nursing homes to discuss the program with residents.

· **Removal of Barriers**

Discuss the major barriers to transitioning nursing home residents to the community and maintaining them there along with the proposed plan for removing these barriers. Included in this section will be use of the direct services funding plus services available through partnership with housing or other state agencies.

· **Waivers**

The application should contain an initial assessment of the waivers, if any, that the state feels are necessary to implement the program. States may need to request Medicaid waivers to provide services not currently covered under the Medicaid program. To the extent that a State plans to amend an existing home and community based services waiver to add services not currently available under the waiver or to request a new home and community-based services waiver under section 1915(c) to accommodate individuals served under the demonstration and provide needed services and supports, the State must describe its plans for doing so and meet all applicable cost-neutrality requirements.

· **Partnerships**

Describe any partnership with other federal, state or local agencies whose services are

part of the continuum of care required to sustain nursing home residents in the community. Also, describe any partnership that will be undertaken with the community-based agencies, and/or endorsements you have received form long-term care advocacy groups in your state.

- **Monitoring Plan**

  Describe plans for safeguarding the transition population through and after the transition process. Persons moving to the community may require both initial assistance in re-acquiring the skills necessary to function independently as well as ongoing assistance to maintain community residence. State should describe how they will monitor the safety of the transition process including how they will involve disabled individuals and their families in this monitoring process.

- **Housing**

  Describe plans for working with the U.S. Department of Housing and Urban Development, the State housing authority, independent living center and similar consumer directed organizations, other organization and individuals, and Medicaid beneficiaries to locate and design affordable community-based housing. It is important that housing resources be integrated within the community; and that affordable and accessible housing, whether for rent or sale, be made available to individuals regardless of their disability.

C. Describe milestones and work products to be accomplished during the grant period. The purpose of this section is outline clearly what the state hopes to achieve in the allotted two year grant period.

- Examples of work products include a completed waiver application, an analysis of current nursing home resident functional characteristics.

- Timetable for accomplishing the major tasks to be undertaken as described above. Please include key dates relevant to the proposed project (e.g. state budget cycles and legislative sessions).

- Expected system reforms.

D. Describe the project organization and staffing including.

- Proposed management structure and how key project staff will relate to the proposed project director, the lead organization, and, the interagency working group. Brief

- biographical sketches of the project director and key project personnel indicating their qualifications, and prior experience for the project. Resumes for the key project personnel should be provided as an attachment.

E. Provide a set of endorsements of the support and commitments that have been pledged for the proposed project (e.g. cooperation from other state agencies, the executive branch, the legislative branch, insurers, business groups, disability and aging communities, nursing home associations, etc.). Individual letters of support should he included as attachments.

5. Program Budget

The proposed budget for the program should distinguish the administrative portion of the grant from the direct services portion of the grant.

Appendix Two

Review Criteria

1. **Technical Approach** (40 points)

The State must define how it will design and implement its project, addressing the following areas:

- o characteristics and estimated number of the target population to be offered the opportunity to transition to the community, and the geographic location of nursing homes from which they will be drawn;
- o approach for identifying beneficiaries, gaining access to them and educating them about their choices;
- o partnerships with consumer and provider agencies at the local, state and federal level;
- o process for identifying and remedying barriers to community-based care;
- o benefits and services, including consumer-directed attendant care;

o quality assurance/ monitoring strategies; and

2. **Level of Commitment to the Project** (25 points)

States must demonstrate their commitment to this initiative. States are encouraged to provide any documentation which would provide evidence that it is committed to providing community based options to nursing home residents. Additional points will be awarded to applications form States that provide greater support for the proposed transition program. Such support can be demonstrated by the extent to which States use their own resources in combination with grant funds, and by the extent of agency coordination and cooperation in creating a true continuum of care for supporting disabled persons in the community.

3. **Project Scope** (20 points)

Applications will be judged based on the scope of the proposed program in relation to the size of the nursing home population in the state. Additional points will be given to applications in which the proposed program has the potential to provide transition options to a larger number of nursing home residents. Additional points will also be given to applications from States for whom the proposed program represents a major improvement to infrastructure for supporting disabled persons with home and community based care.

4. **Staff** (15 points)

Identification of key program staff and evidence that key staff (including the project director) are qualified and possess the experience and skills to implement and conduct the program within the available time frames.

ENVIRONMENT:

The past years have been a continuous struggle for the nursing home industry. The continued reductions in resources from government funding cuts has been coupled with an increase desire for more service. That desire has been joined with a fierce need to have tougher oversight of nursing home service coming from the White House and HCFA. The need to balance the budget and be tough on those who provide service services to the elderly has caught the nursing home industry in a crossfire that has resulted in major losses to the companies providing service. Top ten corporations in the country have seen a loss of capitalization of over $10 billion just this last year. (From $15 billion to $5 billion) One company alone recently announced layoffs of 10,000 employees.

Attempts to solve the problem have gone on relatively deafs ears. The Administration has pushed cuts in the Medicare reimbursement, elimination of the simple Medicaid reimbursement protection (the Boren Amendment) and pushed HCFA to be much more aggressive in the oversight and enforcement of oversight regulations.

The culmination of the insensitivity of the Administration to the industry occurred a week ago. The industry has gone out of its way to support the Administration. Yet, the President recently announced nursing home operators would be viewed the same as telemarketing scam artists and be held liable to criminal penalties and jail terms---a major embarrassment. At a time the industry is trying to work with the Administration to solve its resources and oversight problems, the White House is slamming some of its biggest supporters.

TIME FOR A CHANGE:

The industry needs help in two ways. and needs it fast. First, there can be an influx of cash into the SNF Medicare system. That can be done by simply raising rates, by offering facilities choices of a rate base, and by changing the market basket index to reflect current acuity's of patients. Additionally, the Administration can immediately send the signal to the Congress that it is willing to solve the problem created by capping Part B therapies at $1500 per year. The signal should also be sent that there is a willingness to solve the problem of insufficient resources that are present to care for the "sub acute" class of residents.

The target is to put $7billion back into the system. That is the figure that the CBO has said that was "oversaved" from BBA target. (BBA saved $9.5, actual numbers are now $16.6 billion.)

Second, the President can sit down with the industry and start the dialogue to improve quality of care in nursing homes. It does no good to continue to beat up on the industry through enhanced penalties. They have not worked for over 20 years. It does help to set positive incentives and to focus on the outcome of services and improving the quality of life of the elderly population. Such a meeting should be held within the next few weeks.

CONCLUSION:

By pushing to increase payments to the SNF industry and by pushing to enhance care through positive means, the President and the Administration will take a forward move that will solve the problems of the industry, put the President in the position of caring for the elderly, and will take away the criticism that will soon be leveled at the White House by the industry and the Congress. It will help to continue to posture the Democrats as providing help and care to the elderly and the care givers, while currently the atmosphere is one of non caring and combat.

To: Nancy Ann
From : Chris

Attached is a summary of policy options to increase cash flow to skilled nursing facilities that was prepared by Bruce Yarwood.

The two options which internal HCFA sources have indicated can be implemented administratively are:

1. Raising reimbursement rates under PPS
2. Offering facilities a choice of a base rate

Hope this is useful. Please call with questions and to discuss this issue further.

MEETING WITH NURSING HOME INDUSTRY

Today, you are meeting with Steve Richetti, Bruce Yarwood, Alan Solomont, and Vic Fazio to discuss the current financial problems facing the nursing home industry. The industry advocates are extremely upset about the President's recent radio address unveiling new criminal and civil penalties for abusive and neglectful nursing home operators, and believe to impose these new restrictions on nursing homes while these providers are struggling with significant financial losses (over $10 billion in 1998) is unconscionable.

Bruce and Alan have provided you with a list of policy changes that they feel will provide the necessary cash flow increase to nursing homes nationwide. These include:

- **Raising reimbursement rates.** The BBA changed the payment reimbursement rate from cost based reimbursement to a prospective payment system in July of 1998. The new system, which uses historical data from 1995, is in the first year of a three year transition period to phase in the new payment system. We have only been hearing complaints from the sub-acute providers; it appears that traditional nursing homes have been able to adjust quite well to the new payment system. There are a number of changes we can make to PPS in order to ensure that it adequately reimburses for some services, including non-therapy ancillary services, that subacute care providers deliver. It is probably too soon to tell whether this type of change is actually necessary.

- **Offering facilities choice of a base rate for the new prospective payment system.** As we transition from a facility specific rate to a full Federal rate under the prospective payment system, some nursing facilities have realized that they will actually have higher rates of reimbursement under the Federal rate than under the transition rate. This proposal would allow facilities to choose to be reimbursed under the new Federal rate rather than going through the transition period. We discussed this proposal last year during the budget negotiations; however, the industry rejected it because we sought to implement it in a budget neutral fashion, which would mean lowering the Federal rate across the board. It is also important to note that although some industry representatives believe that we could implement this change administratively, our OGC has stated conclusively that this proposal would require legislation.

- **Changing market basket index to reflect current patient acuity.** This proposal would use the producer price index (what nursing homes currently charge for the services they provide) rather than the market basket index to determine reimbursement rates. As we do not do this for any other Part A providers, it would constitute a significant change in policy.

- **Eliminating Part B therapy caps.** The Administration never proposed or advocated for the therapy caps provision in the BBA. We believed it to be a policy based on an arbitrary standard that had little policy rationale. We have indicated to the House and Senate leadership that we would be open to discussing modifications to the policy. However, we have to carefully evaluate policy options and financing offsets before making any changes to the BBA.

- **Engaging in a dialogue with the industry to improve quality of care.** We are open to meeting with the industry to discuss new ways to improve the quality of care provided in nursing homes.

Bruce states in his policy paper that the goal of these changes is to put $7 billion back into the skilled nursing facility system nationwide. He states that $7 billion is the amount that was "oversaved" from the BBA target.

However, it is important to note that the $7 billion estimate is not accurate because the two baselines are not comparable. The 1997 CBO baseline includes a lot of part B costs; however, the 1999 baseline only includes part A costs. CBO recently did a new analysis of the two baselines in order to be able to determine the effect of the BBA changes on nursing homes. The analysis indicates that the 1999 baseline is really only $200 million lower than it would have been without the BBA changes over 5 years.

UNITED STATES SENATOR • IOWA
CHUCK GRASSLEY

press@grassley.senate.gov http://grassley.senate.gov

Floor Statement of Senator Chuck Grassley, of Iowa
Chairman of the Senate Special Committee on Aging
Regarding the "Rumors of Nursing Home Bankruptcy"
Wednesday, May 5, 1999

Mr. President, through reports in the press and in discussions with my colleagues, I have received information indicating that one, possibly two, large nursing home chains may be facing bankruptcy in the near future. I'd like to address this issue here today on the floor.

The news of impending bankruptcies has a human side and a financial side. I want to discuss the human side first.

Should one or both of these nursing home chains go bankrupt, we would have an immediate challenge to ensure the continued care of the 35,000 to 70,000 residents currently in their care. This would be a significant task. Nursing home residents are frail and are not easily moved. Moving them runs the risk of causing "transfer trauma," a condition that can result in death. Therefore it is critical that we keep focused on preventing avoidable harm and take precautions to prevent this from happening.

I have introduced legislation to ensure that the quality of patient care is monitored during bankruptcy. My legislation requires the appointment of an ombudsman to act as an advocate for the patient. This change will ensure that judges are fully aware of all the facts when they guide a health care provider through bankruptcy. Prior to a Chapter 11 filing or immediately thereafter, the debtor employs a health care crisis consultant to help it in its reorganization effort. The first step is usually cutting costs. Sometimes, this step may result in a lower quality of patient care. The appointment of an ombudsman should balance the interests between the creditor and the patient. These interests need balancing because the court appointed professionals owe fiduciary duties to creditors and the estate but not necessarily to the patients.

There will be occasions which illustrate that what may be in the best interest of creditors may not always be consistent with the patients' best interest. The trustee's interest, for example, is to maximize the amount of the estate to pay off the creditors. The more assets the trustee disburses, the more his payment will be. On the other hand, the ombudsman is designed to insure continued quality of care at least above some minimum standard. Such quality of care standards currently exist throughout the health care environment, from the health care facility itself to State standards and Federal standards.

Consider the following excerpt from the *Los Angeles Times* on September 28, 1997, which describes the unconscionable, pathetic, and traumatic consequences of sudden nursing home closings:

"It could not be determined Saturday how many more elderly and chronically ill patients may be affected by the health care company's financial problems. Those at the Reseda Care Center in the San Fernando Valley, including a 106-year-old woman, were rolled into the street late Friday in wheelchairs and on hospital beds, bundled in blankets as relatives scurried to gather up clothes and other personal belongings."

The presence of an ombudsman should help prevent a recurrence of instances similar to what I just described, where trustees quickly close health care facilities without notifying appropriate state and federal agencies and without notifying the bankruptcy court.

I began discussions with the Health Care Financing Administration at the beginning of April to urge them to take seriously the rumors we were hearing about possible nursing home bankruptcies and to encourage them to make preparations. I called for contingency plans that would prepare, well in advance, for the daunting challenges bankruptcies would pose to various federal and state agencies. HCFA briefed the staff of the Aging Committee, as well as staff from the Finance Committee and Budget Committee. While the HCFA staff appreciated the severity and size of the problem of ensuring resident safety in the event of a bankruptcy, they did not have a plan - or even a plan for a plan.

I wrote to the HCFA Administrator urging her to take the effort very seriously, to keep at the planning and to stay in touch with my office. Only on April 28th did I hear from her office that we could expect to see the plan in the next two weeks. That is why I wrote to her again on April 29, to tell her to get on with the effort and to let me and interested Members know of the plan to ensure that the people in the affected nursing homes will be protected.

Once we are assured that residents will be safe we can turn to the financial part of the bankruptcies. Now I will address these financial issues.

Before we take any action involving the taxpayers' hard-earned dollars, we should ask, and get solid answers to, some critical questions.

The first is this: if the rumors of financial distress are true, how is it that some providers are in such distress while others seem not to be? What factors have put certain companies at particular risk? The answer to that question will go a long way to help us know what kind of response their situation demands.

At this point, I'd like to make an observation about the Medicare element of this situation. A Prospective Payment System (PPS) for Skilled Nursing Facilities was mandated by the Balanced Budget Act of 1997 (BBA). Some argue that, comparing CBO's 1997 baseline with its 1999 baseline, Medicare has saved $7 billion more than originally anticipated, and that this pushed these companies over the edge.

But did it? CBO has recently clarified its baselines, explaining that the alleged difference between the two baselines comes from an apples-to-oranges comparison: the 1997 baseline included Part B spending on patients in these facilities, while the 1999 baseline does not. When apples are compared to apples, CBO tells us, the Medicare Part A baseline for Skilled Nursing Facilities has decreased by only $200 million over five years. Of course this doesn't tell us what is going on in

the real world. It only tells us that the discussion should not be about CBO's baselines, it should be about what is really is going on out there.

Next, questions have been raised by shareholders, in class action suits against the management of these companies, about the competence and effectiveness of the management of these two companies. Did these companies try to grow too large, too fast? Did they take on more debt than they could manage? Was their business strategy flawed? A host of questions need to be answered about the internal operation of these companies to see if they were being well run before we assume that more taxpayer dollars will fix the problem. Otherwise we could wind up subsidizing the mistakes of well compensated executives.

These are serious questions that should be answered by the committees of this body. We should make full use of the evaluators who work for Congress. And the Administration should devote some effort to the inquiry as well. We need to understand the problem before we propose a solution. We should make haste to get these answers and not rush blindly into what could otherwise be a thoughtless bailout. Mr. President, I yield the floor.

CBO BASELINE - PAYMENTS TO SKILLED NURSING FACILITIES
(Medicare Fee for Service Spending, by Fiscal Year in Billions)

04/29/99

	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Total - 02	Total - 07
1 January 1997 Baseline \1	**$5.3**	**$7.0**	**$9.1**	**$11.1**	**$12.8**	$14.1	$15.4	$16.7	$17.9	$19.2	$20.5	$21.8	$23.3	$24.9	$26.6		
growth rate	**40%**	**32%**	**30%**	**22%**	**15%**	11%	9%	8%	7%	7%	7%	7%	7%	7%	7%		
2 January 1997 Baseline for SNF Payments Under Part A Only	**4.7**	**6.3**	**8.1**	**10.0**	**11.7**	12.9	14.2	15.3	16.5	17.7	16.9	20.2	21.6	23.1	24.8		
3 BBA Estimate for SNF PPS Policy \2				0.0	0.0	-0.1	-1.2	-2.1	-2.7	-3.2	-3.7	-4.0	-4.4	-4.9	-5.4	-9.2	-31.6
4 March 1999 Baseline	**4.7**	**6.3**	**8.1**	**10.0**	**12.2**	**13.2**	12.7	12.9	13.6	14.3	15.2	16.2	17.2	18.3	19.5		
growth rate	**44%**	**35%**	**30%**	**23%**	**21%**	**9%**	-4%	2%	5%	5%	6%	6%	6%	7%	6%		
March 1999 Baseline Minus the January 1997 Baseline for SNF Payments Under Part A \3				0.0	0.5	0.8	-1.5	-2.4	-2.9	-3.4	-3.7	-4.1	-4.4	-4.8	-5.3	-9.4	-31.7

Note: Bold font indicates actual outlays known at the time the baseline was estimated.

1. The January 1997 baseline and the March 1999 baseline reflect two different concepts:
   Both baselines include payments made to SNFs for beneficiaries enrolled in Medicare Part A and in a Part A-covered inpatient SNF stay.
   The January 1997 baseline also included payments for services furnished in SNFs and made under Part B for beneficiaries who were not enrolled in Medicare Part A or were not in a Part A-covered inpatient SNF stay. The difference is $0.6 billion in 1992 growing to about $2 billion per year by 2007.
2. The BBA cost estimate shows changes in Medicare spending attributable to the SNF PPS policy, not changes in Medicare payments to SNFs. Changes in Medicare spending include the effect on payments to other providers as a result of the SNF policy.
3. Main differences between the January 1997 Baseline for SNF Payments Under Part A Only and the March 1999 Baseline:

a.) Effects of the Balanced Budget Act's SNF PPS policy and changes in payments to SNFs as a result of other BBA policies, such as the hospital transfer policy.
b.) Unanticipated (in January 1997) reductions in outlays due to fraud and abuse control efforts by the Office of the Inspector General and Department of Justice.
c.) CBO projected inflation rates in March 1999 that were lower than the rates projected in January 1997. The effect of lower projected inflation was compounded by HCFA's rebasing of the SNF market basket, which further reduced projected payment updates.
d.) Revised estimates of HMO enrollment and beneficiary demographics.
e.) During 1998 and 1999, an increase in the lag between when services are provided and when payments are made.

Post-it™ brand fax transmittal memo 7671 | # of pages ▸ 1

To DEVORA KADLER	From MIKE BURNS
Co. WHITE HOUSE	Co. SEN. AGING. COMM.
Dept. DOM. POL. COUN.	Phone # 224-5367
Fax # 456-5557	Fax #

DOJ Response to Latest HHS Nursing Home Legislation Comments
(Draft - 4/15/99 - Draft)

Provisions HHS wants included in the statutory language	DOJ Response
I.A - Secretary to have prior approval of injunctive actions	DOJ believes this should be in the Memorandum of Understanding. Placing this in the statute could give rise to litigation and discovery as to whether DOJ had obtained the necessary approval. Since an MOU would be binding on both parties and would remain in force until both DOJ and HHS agreed to change it, there should be no concern about one agency unilaterally deciding to amend the MOU.
I.B - Language preserving the Secretary's "authority, including enforcement authority, under the SSA."	Since the new statute does not amend the SSA, the purpose and effect of this provision is not clear. If the language is purely symbolic, it is not necessary. If HHS believes it will substantively alter the authority of HHS or DOJ, we would like a more complete explanation of its effect.
I.C - Requirement that civil actions be approved in advance by AG, DAG, ASG, or AAG	This requirement is unacceptable. DOJ had offered to include - in the MOU - a reiteration of the existing dispute resolution mechanism (which requires a US Attorney's Office that wishes to take a position contrary to the position of the relevant programmatic agency to obtain approval at Main Justice).
I.D - Administrative authority for Secretary to impose sanctions against "individuals in chains and management companies.	DOJ has no conceptual objection to giving HHS authority to impose administrative sanctions against nursing home chains and management companies (indeed, DOJ believes this would be desirable). (Note -- the HHS paper refers to "individuals in chains and management companies" - DOJ would like clarification as to whether these sanctions are directed against corporate entities, individual persons, or both). DOJ would like to see actual legislative language before endorsing this beyond the conceptual stage. Also, we recommend against putting such provisions in Title 18.

Provisions HHS wants included in the Memorandum of Understanding	
II.A – Requirement that DOJ notify HCFA within 2 days "whenever it receives, or hears allegations of such conditions, that allege immediate jeopardy of patient harm" or within 10 days of allegations of actual patient harm.	DOJ objects to the specific requirements (including the unreasonable time limits) but agrees that some notification process is appropriate. In mid 1998, DOJ issued a Memorandum to all US Attorneys' Offices and Civil and Criminal Division attorneys requiring them to refer certain allegations of patient harm or abuse to appropriate programmatic agencies (HCFA and the HHS OIG commented upon this Memorandum). DOJ believes the agencies should review that memo to determine if it effectively captures the sought-after notification and adapt this to the MOU.
II.B – HCFA will promptly notify DOJ of disposition of actions taken in response to notifications made under II.A, supra.	No objection.
II.C – HCFA will refer to DOJ "cases of egregious noncompliance as that term is defined by the mutual agreement" of DOJ and HHS.	DOJ believes that HCFA should refer matters where there is credible evidence of violations of the new statute (i.e., credible evidence that an individual or entity has engaged in a pattern of violations of nursing home regulations where such violations have resulted in patient harm). DOJ believes it would be productive to further define in the MOU the circumstances that might rise to such a level.
II.D – A request for written certification to undertake a prosecution [NB – presumably, a request to one of the senior officials listed in I.C, supra] must include HCFA's position on the matter. If HCFA objects, the AAG must obtain views of HCFA Administrator (or designee) prior to authorizing that an action go forward.	Since DOJ objects to the requirement in I.C, this requirement is unnecessary. The MOU should require advance consultation with HCFA on civil and criminal enforcement actions. DOJ also has offered to include a reiteration of the existing dispute resolution mechanism (which requires AAG or higher approval of actions where the programmatic agency [HCFA] objects to the position taken by a US Attorney). Moreover, if such a requirement (i.e., a mechanism to document HCFA's views on whether to pursue a particular action) were to be drafted, there would need to be an explicit deadline (e.g., 10 working days) on a response from HCFA.

II.E – Any action taken by DOJ will be based on a set of definitions of key terms used by HCFA so as not to create conflicting standards that facilities will need to meet	DOJ agrees that the MOU should define key terms in a manner that is consistent with HCFA rules and regulations (in fact, that is why the statute refers to violations of nursing home rules and regulations). These terms should be spelled out in the MOU.

Fax Cover Page

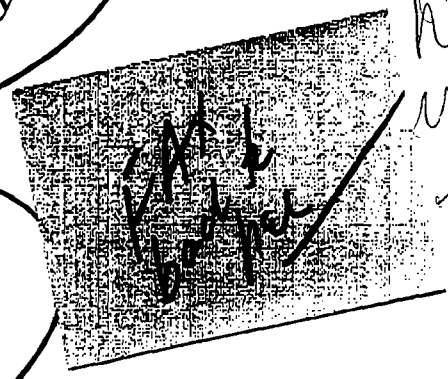
To: **Bruce Yarwood**

Subject: Radio Address - Elder Crime, Fraud and Abuse
Date: 04/19/99 12:23 PM
Pages: 3 , including cover page

From: Barbara D. Woolley
Agency:
Organization:

Office Phone:
Fax Phone:

Deborah - this is having lunch w/ Bruce on Thursday. FYI. Barbara



Barbara
- this is ridiculous!
- + expansion

Great way to start supporting!

4/22

THE WHITE HOUSE
Office of the Press Secretary
(Bedford, Massachusetts)

Saturday, April 17,1999

RADIO ADDRESS OF THE PRESIDENT TO THE NATION
Roseville Recreation Center, Roseville, Michigan

THE PRESIDENT: Good morning. Of all the duties we owe to one another, our duty to our parents and grandparents is among the most sacred. Today I want to talk about what we must do to strength the safety net for America's seniors, by cracking down on elder crime, fraud and abuse.

For more than six years, we've worked hard to keep our families and our communities safe. And we've made remarkable progress, with violent crime dropping to its lowest levels in 25 years. For elderly Americans who once locked themselves into their homes in fear, the falling crime rate is a godsend.

But the greatest threat many older Americans face is not a criminal armed with a gun, but a telemarketer armed with a deceptive rap. And our most defenseless seniors, those who are sick or disabled and living in nursing homes, cannot lock the door against abuse and neglect by people paid to care for them. So America's seniors are especially vulnerable to fraud and abuse. Therefore, we must make special efforts to protect them.

That is why the 21st century crime bill I'll send to Congress next month includes tough measures to target people who prey on elderly Americans. First we must fight telemarketing fraud that robs people of their life savings and endangers their well-being. Every single year illegal telemarketing operations bilk the American people of an estimated $40 billion. More than half the victims are over 50. That's like a fraud tax aimed directly at senior citizens.

Last year we toughened penalties for telemarketing fraud, but we should stop scam artists before they have a chance to harm America's seniors. My crime bill will give the Justice Department authority to terminate telephone service when agents find evidence of an illegal telemarketing operation or a plan to start one. This new law will send a message to telemarketers, if you prey on older Americans we will cut off your phone lines and shut you down.

Second, we must fight nursing home neglect and abuse. Nursing homes can be a safe haven for senior citizens and families in need. To make sure they are, we've issued the toughest nursing home rules in history, and stepped up investigations at facilities suspected of neglect and abuse. But when one out of four nursing homes in America does not provide quality care to their residents, and when people living in substandard nursing homes have as much fear from abuse and neglect as they do from the diseases of old age, we must do more.

My crime bill gives the Justice Department authority to investigate, prosecute and punish nursing home operators who repeatedly neglect and abuse their residents. With prison sentences of up to 10 years and fines of up to $2 million, these new provisions make clear we will settle for nothing less than the highest quality care in America's nursing homes.

Third, we must fight health care fraud. Every year health care fraud costs American taxpayers billions of dollars, draining resources from programs that benefit our seniors. As Vice President Gore announced last month, my crime bill will allow the Justice Department to take immediate action to stop false claims and illegal kickbacks, and give federal prosecutors new tools to tackle fraud cases.

Finally, we must fight retirement plan rip-offs. My crime bill will toughen penalties for people who steal from pension and retirement funds. To borrow a line from Senator Leahy, who is working closely with us to strengthen the safety net for our seniors, the only people who should benefit from pensions are the people who worked for a lifetime to build them.

Barney — where does this phony figure come from?

I look forward to working with Congress in the coming days to give our senior citizens the security they deserve. That is an important part of our efforts to protect our parents and our grandparents, to advance our values and build a stronger America for the 21st century.

Thanks for listening.

END

Deborah –

Need GAO to cite for 1 out of 4 statin 20 TW Radio Address ASAP

Thanks

CJ

Long-Term Care Companies

One-Year Price Movements

Company	Closing Price on 4/9/99	Closing Price on 3/9/98	%Decline
Vencor	$ .75	$10.38	(92.8%)
Sun Health	$ .88	$18.88	(95.3%)
Advocat	$ 1.94	$ 9.00	(78.4%)
Mariner	$ 2.31	$19.38	(88.1%)
IHS	$ 3.63	$36.00	(89.9%)
Centennial	$ 3.94	$21.25	(81.4%)
Beverly	$ 4.44	$15.50	(71.3%)
Genesis	$ 4.63	$29.25	(84.2%)
NHC	$ 7.69	$34.75	(77.9%)
HCR/Manorcare	$24.44	$46.31	(47.2%)

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Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

Working DRAFT

Quality of Care in Nursing Homes: An Overview

JUNE GIBBS BROWN
Inspector General

JANUARY 1999
OEI-02-99-00060

OFFICE OF INSPECTOR GENERAL

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, is to protect the integrity of the Department of Health and Human Services programs as well as the health and welfare of beneficiaries served by them. This statutory mission is carried out through a nationwide program of audits, investigations, inspections, sanctions, and fraud alerts. The Inspector General informs the Secretary of program and management problems and recommends legislative, regulatory, and operational approaches to correct them.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) is one of several components of the Office of Inspector General. It conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the Department, the Congress, and the public. The inspection reports provide findings and recommendations on the efficiency, vulnerability, and effectiveness of departmental programs.

OEI's New York regional office prepared this report under the direction of John I. Molnar, Regional Inspector General, and Renee Dunn, Deputy Regional Inspector General. Principal OEI staff included:

REGION

Demetra Arapakos

HEADQUARTERS

Susan Burbach

EXECUTIVE SUMMARY

PURPOSE

To describe general conditions in nursing homes and assess the overall capacity of systems designed to monitor and improve quality of care.

This report is based primarily on recent studies conducted by the Office of Inspector General (OIG) on quality of care in nursing homes. It additionally draws upon work completed by the General Accounting Office (GAO), the Health Care Financing Administration (HCFA), and others. The report summarizes steps recently taken and now underway to address weaknesses in the system. It also provides a long term program of action and research needed to assure nursing home care meets government standards for quality of care.

BACKGROUND

While many studies indicate that changes in law and regulations may have had a positive effect on improving the environment and overall health care of nursing home patients, recent reports by HCFA and GAO have raised serious concerns about patient care and well-being. The Senate Special Committee on Aging held hearings in the summer of 1998 on these reports. At the same time, the OIG undertook a series of studies aimed at assessing the quality of care in nursing homes.

Various systems are in place to monitor and promote quality of care in nursing homes. These include the State survey and certification system, the State Long Term Care Ombudsman Program, State resident abuse safeguards, law enforcement, and legislative reforms established by the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987).

We used multiple methods for this report. They consist of an analysis of national nursing home program data, a review of written program procedures, structured telephone interviews, a literature review, and an analysis of nursing home legislation.

FINDINGS

Serious Quality of Care Problems Persist in Nursing Homes

An analysis of currently available program data reveals that problems with quality of care continue to exist in nursing homes. First, according to survey and certification data, 13 of 25 "quality of care" deficiencies have increased in recent years. They include a lack of supervision to prevent accidents, improper care for pressure sores, and lack of proper care for activities of daily living. At the same time, Ombudsman complaints have been

steadily increasing since 1989, and complaints about resident care, such as pressure sores and hygiene, have been particularly prevalent. Since 1995, the OIG has excluded 668 nursing home workers from participation in the Medicare/Medicaid programs as a result of a conviction related to patient abuse or neglect. On a related note, approximately one percent or more of nursing home residents have had an experience serious enough to register an abuse complaint. Lastly, survey and certification data, as well as discussions with survey and certification staff and Ombudsmen, reveal that some nursing homes are chronically substandard.

Experienced officials with inside information based on onsite visits to nursing homes -- including State survey directors, surveyors, Ombudsmen, and Aging Unit Directors -- express some reservations about relying exclusively on program data to gauge conditions in nursing homes. Nevertheless, they confirm that problems persist in nursing homes and particularly cite inadequate nursing home staffing, which can compromise the care provided to residents. The problems they identify are similar to the problems highlighted in their program reporting systems.

Survey and Certification Agencies are Following Required Standard Protocols but Weaknesses in the Survey System Itself Limit Their Effectiveness

State survey and certification agencies monitor nursing home care with timely and standard surveys, complaint procedures, and other State procedures. However, the survey and certification system has several weaknesses, such as the predictability of surveys. Although all States use unannounced surveys, State directors and surveyors believe that nursing homes can anticipate their survey date and modify their procedures to avoid being cited for deficiencies. The system is also limited by weak enforcement, including inadequate follow-up and common inaction on abuse complaints. State directors and surveyors believe that the current process allows deficient facilities too many opportunities to avoid enforcement action. Lastly, survey and certification agencies have a number of staffing constraints and do not always effectively coordinate with Ombudsmen.

While the Ombudsman Program is Well Designed, Inadequate Resources Limit its Capacity

The Ombudsman program has several functions to promote and monitor quality of care in nursing homes, including identifying and resolving complaints, making regular visits to nursing homes, and engaging in a variety of different advocacy activities. While lacking enforcement and regulatory oversight, Ombudsmen act as independent advocates and work solely on behalf of residents to ensure they have a voice in their own care. However, the Ombudsman program is limited by inadequate resources, including inadequate staffing. Only 1 of 10 States in our sample had a paid Ombudsman to bed ratio higher than the standard suggested by the Institute of Medicine. This lack of adequate staffing is particularly evident in the limited extent to which Ombudsmen make

regular nursing homes visits. The program is further constrained by the lack of a common standard for complaint response and resolution, inconsistent advocacy efforts, a lack of support, and limited collaboration with surveyors.

State Systems to Safeguard Nursing Home Residents from Abuse are Inconsistent and Unreliable

Based on findings from a recent OIG audit, "Safeguarding Long Term Care Residents," A-12-97-0003, it appears that some weaknesses exist in State efforts to safeguard nursing home residents from abuse. This audit revealed great diversity in the way States systematically identify, report, and investigate suspected abuse, and it found that there was no assurance that individuals who posed a risk of abuse were systematically identified and barred from nursing home employment. Additionally, a more in-depth audit of Maryland examined eight nursing homes in the State and found that five percent of employees in those homes had criminal records.

New Initiatives Based on Law Enforcement Approaches are Being Developed

Recent initiatives that use the False Claims Act and other law enforcement approaches as a way to strengthen nursing homes are relatively new. National task forces comprised of representatives from the Department of Justice, HCFA, OIG, and others are being formed at the local, State, and national levels. These groups will examine the full range of enforcement issues and develop corresponding action plans for each. By targeting key strategic areas and coordinating among the various agencies responsible for nursing home enforcement, these initiatives appear promising. However, it is too soon to determine their full impact.

Nursing Home Reforms Established by OBRA 1987 Have Not Been Systematically Assessed

The nursing home reforms created by OBRA 1987 impacted both nursing home systems and nursing home care. The OBRA 87 mandated that residents be given certain rights and services and also added several administrative standards that nursing homes are required to meet. It further changed enforcement and survey procedures. While it has now been more than a decade later since this legislation was passed, there has been no systematic assessment of its extensive agenda and no methodical evaluation of whether the reforms it intended are actually working. While some studies have attributed positive changes to OBRA 87, the lack of a systematic review makes it difficult to determine if this major legislation has been successful in improving nursing home care.

AN AGENDA FOR CONTINUING IMPROVEMENT IN NURSING HOME CARE

Since OBRA 1987 was first passed, real improvements have been made in nursing home care. More recently, considerable attention has been paid to addressing persisting concerns about nursing home conditions and systems. In particular, we commend the Health Care Financing Administration (HCFA) for its extensive nursing home initiative since it addresses many of these persisting problems. This initiative includes many individual action items which should result in positive changes.

In addition to what HCFA has already initiated, we are suggesting additional steps to be taken to improve nursing home care. These specific recommendations have been made in recently completed OIG reports. They include:

- enhancing survey and certification staffing and training;
- strengthening the Ombudsman program with increased resources;
- improving nursing home staffing levels, and;
- improving coordination between State survey agencies and Ombudsmen.

We also believe that further evaluation and progress measurement would make an important contribution to efforts to advance nursing home care. We specifically suggest:

- a systematic assessment of OBRA 1987 and
- the creation of a national annual report card on conditions in nursing homes.

We have incorporated action items from HCFA's nursing home initiative, recommendations for additional steps to be taken, current OIG work, and areas requiring further evaluation into one comprehensive, long term agenda to continue improvements in nursing home care. This agenda consists of a three stage approach of immediate action, research and evaluation, and continued progress measurement. The full agenda can be found beginning on page 24.

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INTRODUCTION

PURPOSE

To describe general conditions in nursing homes and assess the overall capacity of systems designed to monitor and improve quality of care.

This report is based primarily on recent studies conducted by the Office of Inspector General (OIG) on quality of care in nursing homes. It additionally draws upon work completed by the General Accounting Office (GAO), the Health Care Financing Administration (HCFA), and others. The report summarizes steps recently taken and now underway to address weaknesses in the system. It also provides a long term program of action and research needed to assure nursing home care meets government standards for quality of care.

BACKGROUND

While many studies indicate that changes in law and regulations may have had a positive effect on improving the environment and overall health care of nursing home residents, recent reports by HCFA and GAO have raised serious concerns about residents' care and well-being. The Senate Special Committee on Aging held hearings in the summer of 1998 on these results. The OIG subsequently undertook a series of studies aimed at assessing the quality of care in nursing homes. This report looks at both the general state of nursing home care as well as the systems designed to oversee that care.

Generally, a nursing home is a residential facility offering daily living assistance to individuals who are physically or mentally unable to live independently. Residents are provided rooms, meals, assistance with daily living, and in most cases, some medical treatment. In 1989 Medicare paid $2.8 billion to nursing homes, an amount totaling 4.7 percent of the Medicare budget. In 1996 this amount had increased to $10.6 billion, totaling 9 percent of the Medicare budget. Medicaid expenditures for nursing homes in 1996 totaled $24.3 billion.

In 1986, the Institute of Medicine conducted a study on nursing home regulation and reported prevalent problems regarding the quality of care for nursing home residents, as well as the need for stronger Federal regulations. Just one year later, GAO reported that over one third of nursing homes were operating below Federal minimum standards. These reports, along with widespread concern regarding nursing home conditions, persuaded Congress to pass the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987). As a part of OBRA 1987, Congress passed the comprehensive Nursing Home Reform Act (PL 100-203). These actions expanded requirements that nursing facilities had to comply with in order to obtain Medicare certification. The Nursing Home Reform

Act also ceded personal rights to nursing home residents, such as the right to be free of physical or mental abuse, and the right to be free from chemical and physical restraints. It additionally altered the enforcement of Federal standards for nursing home care.

Medicare Nursing Home Requirements

The Health Care Financing Administration (HCFA) has the responsibility to act as a "prudent purchaser" by ensuring that nursing homes participating in Medicare and/or Medicaid meet certain requirements for quality environment and services. These requirements are found at 42 Code of Federal Regulations (CFR) Part 483, Subpart B. The Nursing Home Reform Act added to these requirements by introducing an increased focus on the quality of life and care, the importance of the individual resident, the need to help residents reach the "highest practicable level" of functioning, and the requirement that residents be interviewed and assessed.

Nursing homes must "conduct standardized, reproducible assessments of each resident's functional capacity..." within 14 days of admission. Additionally, periodic assessments must occur throughout the duration of a patient's stay in order to continually address their fluctuating needs. With the Nursing Home Reform Act, HCFA developed the Minimum Data Set (MDS) which is comprised of core elements and common definitions used in conducting resident assessments. The Minimum Data Set collects data through resident assessment measures, with subsequent progress or decline documented in electronic format.

The Nursing Home Reform Act additionally established new enforcement provisions, which were enacted when the State Operations Manual (SOM) became effective on July 1, 1995. The HCFA had several process goals during the implementation of these new provisions: promoting consistency through extensive training, linking appropriate remedies to deficiencies, and avoiding unnecessary procedures. Congress recognized that one enforcement response would not be appropriate for all deficiencies. It therefore established enforcement policies that gave HCFA the license to impose a variety of corrective measures for noncompliant facilities. These include: temporary management; denial of payment for new admissions; civil money penalties; termination of the facility; and State monitoring of the facility. States are responsible for establishing their own remedy guidelines.

Following the implementation of the State Operations Manual, HCFA also imposed a number of administrative changes on enforcement procedures . In June of 1995, HCFA enacted a temporary moratorium on the collection of certain lower-level money penalties (CMPs). This moratorium preceded HCFA's decision to alter the State Operations Manual in December of 1996. "Civil monetary penalties are now limited to situations of immediate jeopardy or to nursing facilities that are poor performers or have serious deficiencies that are not corrected at the time of a revisit." Additional changes by HCFA redefined the scope of deficiencies, permitted States to avoid revisits in facilities that

have lower level deficiencies, and established new terms to define facilities that are not in substantial compliance.

Nursing Home Systems

Survey and Certification. All nursing homes participating in Medicare and/or Medicaid must be certified as meeting certain Federal requirements. The Nursing Home Reform Act defines the State survey and certification process for determining nursing home compliance with these Federal standards. The HCFA is responsible for certifying Medicare and dually-eligible facilities, while States are responsible for Medicaid only facilities. Nursing home certification is achieved through routine surveys, and HCFA contracts with States to perform such surveys for Medicare and dually-eligible nursing homes, in addition to those they perform for Medicaid nursing homes.

State surveys determine the compliance or noncompliance of nursing homes. When a nursing home fails to meet a specific requirement, surveyors give it a deficiency or citation. Generally, there are 20 principles that are considered in the citation of deficiencies on the HCFA-2567. Surveyors also provide the reasons justifying any resulting enforcement action and the record on which to defend that action in the appeals process. State survey teams generally consist of multi-disciplinary professionals and must include a registered professional nurse. Other professionals who may be on the survey team include social workers, therapists, dieticians, pharmacists, administrators, and physicians.

Each State is also required to maintain written procedures and adequate staff to investigate complaints of violations at nursing homes. States must review all allegations of resident neglect and abuse, and misappropriation of resident property. All allegations, regardless of source, must be reviewed in a timely manner. If an allegation is found to have occurred, the State must notify in writing, the individuals implicated, and the administrator of the nursing home where the incident transpired.

A new survey and certification process was implemented in 1995. All nursing facilities are now subject to an unannounced standard survey "no later than 15 months after the date of the previous standard survey." Since the Statewide average interval between standard surveys "must be 12 months or less," this creates a Federal standard survey window between 9 and 15 months. Each standard survey includes a stratified case mix of nursing home residents, and measures their medical, nursing and rehabilitative care, dietary and nutrition services, activities, social participation, sanitation, infection control, and physical environment. Written plans of care are reviewed to determine their adequacy and an audit of residents' assessments are conducted to determine the accuracy of such assessments. There is also a review of facility compliance with residents' rights.

In addition to regular surveys, States also conduct "special" and "extended" surveys.

Special surveys may be conducted within two months of any change in ownership, administration, management, or director of nursing to determine if the change is having an effect on the quality of care in the nursing home. Extended surveys are performed immediately or within two weeks after the standard survey completion, on those nursing homes found to have provided substandard quality of care. The survey team reviews the policies and procedures that produced the substandard care, expands the size of the sample of resident's assessments, reviews staffing, in-service training, and if necessary, contracts with consultants.

Within two months of the State survey, HCFA conducts validation surveys on a representative sample of nursing homes in each State utilizing the same survey procedure as the State agency. Recently, some HCFA regional offices have chosen to conduct these validation surveys simultaneously with the State. The HCFA must survey at least five percent of the number of facilities surveyed by the State each year, and this number must never be less than five surveys a year.

In order to improve the survey process, the State Agency Quality Improvement Program (SAQIP) was developed to establish a process for State agencies and HCFA regional offices to work together to develop the State's individual quality improvement plans (IQIPs). The regional office will assist the State by providing training, technical assistance, and support as necessary and appropriate. These individual plans are tailored to the specific needs and circumstances of each State, and are revised and improved based on changing needs. The SAQIP is designed to promote quality and ongoing improvement in survey and certification activities, and applies to all aspects of the survey and certification process.

The HCFA's Online Survey Certification and Reporting System (OSCAR) came online in October 1991. The HCFA uses OSCAR in its survey of Medicare and Medicaid providers to monitor State agency and provider performance. The OSCAR contains data for the current and 3 previous surveys. Some of the data is overwritten as new information is entered (e.g. number of beds, address, and employment information), but deficiency data remains and is tracked historically. The HCFA recently began tracking the scope and severity of deficiencies historically as well. Part of the OSCAR data is self-reported information by the nursing homes about the facility and its' patients. The remaining data is information generated by the surveyors and is based on deficiencies. The Federal regulations detailing survey requirements are classified into 17 major categories. The specific survey requirements within these categories were consolidated from 325 individual items to 185 items on July 1, 1995.

Ombudsman Program. In response to growing concerns about poor quality care in nursing homes and to protect the interests of residents, the State Long Term Care Ombudsman program was established in 1978 in the Older Americans Act. The Ombudsmen advocate on behalf of elderly residents of all long term care facilities, including nursing homes, to ensure they have a strong voice in their own treatment and

care.

The Ombudsman Program operates in all fifty States and in hundreds of local communities, and uses both paid and volunteer staff. The program receives funding from Federal, State and local levels, and is overseen by the Administration on Aging (AoA). Most State Ombudsmen operate within the State Unit on Aging, some of which are independent while others are part of a larger State umbrella agency. The remaining State Ombudsman programs are contracted out and administered by an entity separate from the State Unit on Aging. These programs are operated by non-profit organizations, legal services agencies, or by freestanding Ombudsman agencies.

State Ombudsman programs have multiple functions that are mandated by law, many of which are closely tied to ensuring quality care for long term care residents. They include:

- identifying, investigating, and resolving complaints;
- protecting the legal rights of patients;
- advocating for systemic change;
- providing information and consultation to residents and their families; and
- publicizing issues of importance to residents

States have recently started to collect and report data under a new system. In FY 1995, States began to systematically collect and report data under the National Ombudsman Reporting System (NORS). Prior to NORS, States reported data to AoA which was of limited use due to the lack of common definitions for key data elements. The NORS was created in response to earlier recommendations made by the General Accounting Office and the Office of Inspector General and was developed by the Ombudsmen themselves. It includes more specific data elements than were reported before NORS. For example, it separates complaints by type, distinguishes between complaints and complainants, counts unresolved complaints, suggests standardized measures for nursing home services, and reports program funding streams. Twenty-nine States reported under NORS in 1995 and all States did so in 1996 and 1997.

Resident abuse safeguards. Federal regulations require States to establish a registry of nurse aides that includes information on any aide found guilty of abuse or neglect. Regulations also mandate that nursing homes not employ individuals who have been found guilty of abusing or neglecting nursing home residents. States are additionally required to provide criminal information to the OIG national database, which is then used to publish a monthly exclusion list. However, there is no Federal requirement to conduct criminal background checks of all current or prospective employees of Medicare and/or Medicaid participating nursing homes.

Other procedures have also been established to coordinate the reporting of resident abuse allegations. Each State is required to designate a coordinator with central State authority to receive complaints of mistreatment or neglect of nursing home residents. While this

individual or entity may be located in any number of State agencies or within a designated complaint unit, the responsibility is often assigned to an employee of the State survey and certification agency.

Law enforcement. Several different agencies have responsibility for nursing home law enforcement, including the Department of Justice, the OIG, and State agencies such as the State Attorney General. The local police force also plays an enforcement role. A nursing home facility, owner, or other employee (such as a nurse aide or administrator) may be excluded from participation in Medicare and Medicaid after appropriate enforcement action is taken.

Recently, poor quality of care has been the basis of a prosecution under the False Claims Act. When providers submit claims for reimbursement, they certify either explicitly or implicitly that the services provided meet professional standards; if they "knowingly" present a claim for substandard services, then they could be liable under the False Claims Act. Thus, under appropriate circumstances, the Government can use the False Claims Act to prosecute a provider who knowingly presents false or fraudulent claims to the government for substandard care in nursing homes. The two major cases where the False Claims Act has been used involve grossly deficient diabetes monitoring, pressure sore care, and other nursing care. In both the landmark 1996 case against Geriatric & Medical Cos., Inc. and its Tucker House facility and the 1998 case against the Chester Care chain of four nursing homes, the OIG obtained civil settlements for $500,000 each. As part of the settlement agreements, the companies were required to develop comprehensive compliance programs. In addition, in the Chester Care case, the company was required to pay for a temporary manager and monitor to oversee provision of care.

Legislative reforms (OBRA 1987). As previously noted, the OBRA 1987 legislation and ensuing regulations established a framework for nursing home reform. It specifically provided an agenda for nursing home care by mandating that residents be given certain rights and services and adding several administrative standards that nursing homes were required to meet. It also established new survey and enforcement requirements, including making surveys more resident focused and augmenting existing enforcement options.

Prior Studies and Recent Initiatives

Several studies have been completed which have examined the survey and certification process. One recent study entitled "The Regulation and Enforcement of Federal Nursing Home Standards," written by Charlene Harrington and published in March of 1998, details problems with nursing home certification. She challenges the declining State deficiency averages by raising the notion that the enforcement process may be weakening rather than nursing facilities improving quality of care.

Furthermore, "The National State Auditors Association Joint Performance Audit on Long-Term Care," completed in May of 1998 by the Louisiana Office of the Legislative

Auditor, compiled information from ten States regarding survey and certification concerns. Issues discussed include licensing, inspection, sanctions, complaints, and reimbursement. The audit findings conclude that States should vary the timing of inspections, evaluate how aggressively they are imposing State sanctions on facilities with deficiencies, and avoid delaying the investigation of complaints.

Many studies have also reported on the progress and impact of the Ombudsman Program. One of the most recent, "Real People, Real Problems," published in 1995 by the National Academy of Sciences' Institute of Medicine, looked at the Ombudsman program overall. This study reported on State compliance, conflicts of interest, effectiveness, resources, and the need for future expansion of the program. It found that, overall, the Ombudsman program is effective. It also reported lack of access to Ombudsman services by residents and their families, disparities in Ombudsman visitation patterns and service provision, and uneven legal services available to Ombudsmen.

Additionally, the Inspector General issued several reports on the Ombudsman Program in 1991 and 1992. First, "Successful Ombudsman Programs," (OEI-02-90-02120), the main report in a series of reports on the Ombudsman program, found that successful programs are highly visible and obtain adequate funding and support. Furthermore, "State Implementation of the Ombudsman Requirements of the Older Americans Act," (OEI-02-91-01516), found, among other things, that State program staffing and long term care facility visitation varies significantly. It also found that Ombudsmen use many methods to increase their visibility.

In July, 1998, the President announced a new nursing home care initiative to provide enhanced protections and to target needed improvement in nursing home care. Proposed actions include checking criminal backgrounds of nursing home workers, establishing a national registry of employees convicted of abusing patients, targeting nursing home chains with poor records, cutting off inspection funds to States with poor records of citing substandard quality of care, publishing annual nursing home surveys on the Internet, increasing Federal oversight of State inspections, providing additional training to State officials, changing the survey schedule to make them more unpredictable, and increasing the number of night and weekend surveys.

In conjunction with the President's nursing home initiative, the Secretary released a report to Congress in July of 1998, a "Study of Private Accreditation (Deeming) of Nursing Homes, Regulatory Incentives and Non-Regulatory Initiatives, and Effectiveness of the Survey and Certification System," indicating that significant improvements in the quality of care had been made since 1995. These improvements included more appropriate use of physical restraints, anti-psychotic drugs, anti-depressants, urinary catheters, and hearing aids. However, the report did find a need for further improvements by States, nursing homes, and others. Additional steps will be taken to address the problems identified in the report and include tougher enforcement of Medicare and/or Medicaid rules. Efforts will be aimed at preventing instances of pressure sores,

dehydration, and nutrition problems. The following are new approaches aimed at improving quality of care: facilities that have repeat offenses will face sanctions without a grace period; inspections will be conducted more frequently for repeat offenders without decreasing inspections at other facilities; inspections will be staggered; a set amount of inspections will be conducted on weekends; and efforts will be focused on facilities within chains that have a record of non-compliance.

One week after the President's initiative, the General Accounting Office (GAO) published a report examining the quality of care in 1,370 California nursing homes that were inspected from 1995 to 1998. They found 30 percent of the homes had violations that caused death or life-threatening harm to residents, or had understated the frequency of poor care by falsifying medical records. As a result of this report, the US Senate Special Committee on Aging held hearings in July 1998 to discuss the findings on the quality of care in nursing homes.

METHODOLOGY

Multiple methods were used for this report. They include an analysis of national nursing home program data, a review of written program procedures, structured telephone interviews, a literature review, and an analysis of nursing home legislation.

Description of nursing home conditions

Data Analysis

Survey and certification data. We used a purposive sample of 10 States which represent 55.8 percent of total skilled nursing beds nationally. These States are New York, California, Texas, Ohio, Illinois, Pennsylvania, Massachusetts, Florida, New Jersey, and Tennessee. The OSCAR contains data for the current and 3 previous surveys and categorizes deficiencies into 17 major categories. Using the most recently available OSCAR data (from August 4, 1998), 3 of the 17 categories which could determine poor quality of care were analyzed. These are: 1) resident behavior and facility practices, including the areas of restraints, abuse and staff treatment of residents; 2) quality of life, including the resident's ability to make decisions about his or her daily activities and the nursing home's accommodation of his or her needs; and 3) quality of care, including the technical ability of the nursing home to prevent and treat the medical conditions of its residents. Substandard quality of care deficiencies repeated over the last four surveys and abuse complaint data were also examined.

Ombudsman data. Using the same purposive sample of 10 States, we analyzed 2 sets of Ombudsman data. For 1996 and 1997, data from the National Ombudsman Reporting System (NORS) was examined; from 1989 to 1994, data from the pre-NORS reporting system was used. Data from 1995 is not reported due to a lack of comparable data elements for that year. For both pre-NORS and NORS data, figures for both total

complaints and broad complaint categories are presented; for NORS data, 125 specific complaint types were also looked at. Finally, data on Ombudsman program staffing, visitation rates, advocacy activities, and coordination with survey and certification agencies was also examined.

Abuse complaints. Using a fax survey, we obtained data from all 10 States on the numbers and types of nursing home resident abuse complaints. We specifically analyzed data on four types of complaints selected as key indicators of recent abuse trends: physical abuse, inappropriate use of restraints, physical neglect, and medical neglect.

OIG convictions. We reviewed data from the Office of Inspector General on nursing home convictions relating to resident abuse or neglect, from 1976 to 1998.

Literature review

We examined findings on nursing home conditions from several studies, particularly the recent GAO report entitled "California Nursing Homes: Care Problems Persist Despite Federal and State Oversight."

Assessment of nursing home systems

Procedures Review

Survey and certification procedures. For the eight States that have their own survey guidelines which they use in addition to HCFA guidelines, we obtained and reviewed their written program procedures and other related documents. The remaining two States had no survey requirements of their own.

Ombudsman procedures. Written procedures for all 10 sample State Ombudsman programs were obtained and reviewed. Using a structured review guide, these procedures were reviewed to determine the different processes used by Ombudsmen to monitor and promote quality of care in nursing homes. Standards mandated for these processes, such as complaint response times, were also looked at.

Interviews

Survey and certification telephone interviews. A total of thirty structured telephone interviews were conducted. In each of the 10 sample States, one interview was conducted with the State survey and certification director (or designee) and two State surveyors. The two State surveyors were selected randomly from a list of at least 10 surveyors submitted by the State director. During these interviews, information was obtained about the State survey and certification program structure, the processes utilized to monitor quality of care, how deficiencies are addressed, and the satisfaction of State survey and certification directors and surveyors with the process. Information provided

by the directors was compared to that provided by surveyors, and special attention was given to consensus within and among the groups.

Ombudsman telephone interviews. A total of 30 structured telephone interviews were conducted. In each of the 10 sample States, one interview was conducted with the State Ombudsman, one local program Ombudsman, and the Director of the State Unit on Aging or designee. In selecting Ombudsmen from local programs to interview, individuals from a variety of local program structures were chosen. These three groups of respondents were selected to obtain their different perspectives of the program and consensus among the groups was particularly noted while analyzing the interviews.

Literature review

We also conducted a literature review of recent nursing home studies which assessed nursing home systems. We particularly used an OIG report entitled "Safeguarding Long Term Care Residents."

Legislation review

Finally, we reviewed nursing home legislation, particularly OBRA 1987. We identified each of the individual reforms outlined in OBRA 87 and determined which ones had been assessed for impact and outcome. Lastly, we reviewed the mission statement and agenda for recent nursing home law enforcement initiatives.

This inspection was conducted in accordance with the **Quality Standards for Inspections** issued by the President's Council on Integrity and Efficiency.

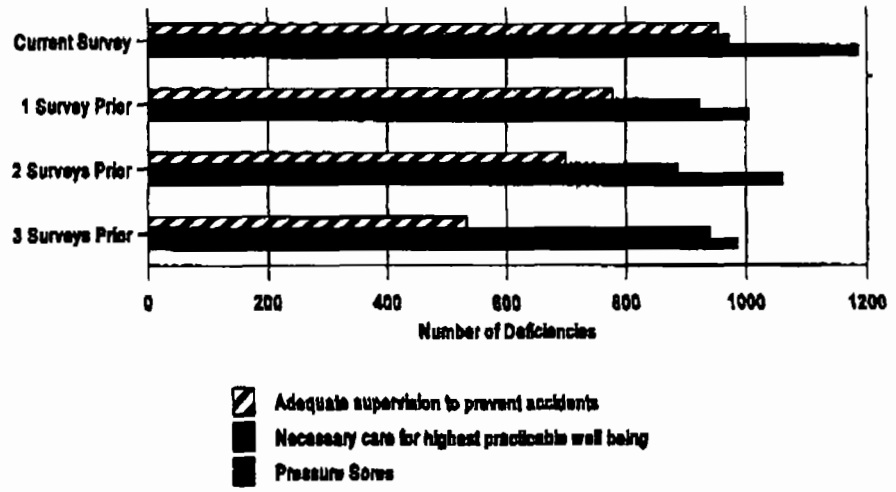
FINDINGS

Serious quality of care problems persist in nursing homes

Survey and certification deficiencies. An analysis of survey and certification deficiencies indicates that problems with quality of care continue to exist in nursing homes. Deficiencies are grouped into one of three main categories, and while two of these categories have been decreasing, many deficiencies in the "quality of care" category have actually been increasing. More specifically, 13 of the 25 deficiencies that make up this category are higher now than they were on the last 3 surveys. These 13 deficiencies were cited 6,413 times on the current survey, compared to 5,246 times three surveys prior, an increase of almost 25 percent. They include a lack of adequate supervision to prevent accidents, a lack of appropriate care for activities of daily living, and improper care for pressure sores. Graph A below shows how some of these serious deficiencies have grown over the prior 3 surveys.

Graph A

Some Serious Quality of Care Deficiencies Have Been Increasing



Deficiencies often lead to further medical problems or indicate other issues. For example, pressure sores could be an indication that residents also have other problems, such as urinary incontinence, malnutrition, or dehydration.

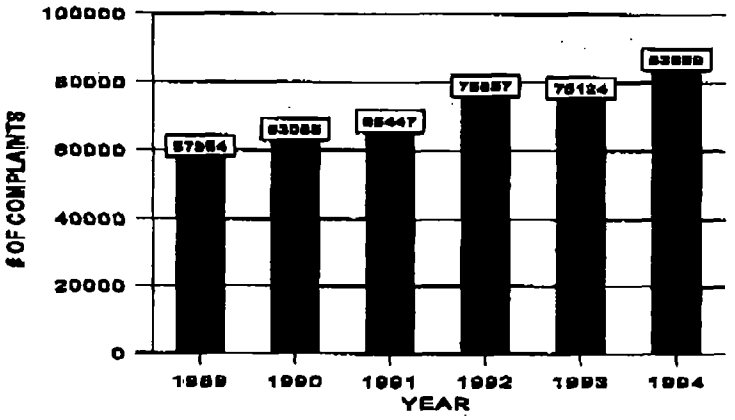
In its recent report entitled "California Nursing Homes: Care Problems Persist Despite Federal and State Oversight" the GAO examined the quality of care in 1,370 nursing homes in California. It found that 30 percent had violations that caused death or life-threatening harm to residents, or had understated the frequency of poor care by falsifying

records. Among the problems it reports are poor nutrition, dehydration, and improper care of incontinent and immobile residents which leads to pressure sores.

Ombudsman complaints. Ombudsman nursing home complaints have also been steadily increasing, as illustrated in graph B below. Based on data from 1989 to 1994, total complaints in the 10 sample States grew from 57,954 to 83,669, an increase of 44 percent. (Due to the transition to a new data system in 1995, we do not have comparable complaint rates for that year).

Graph B

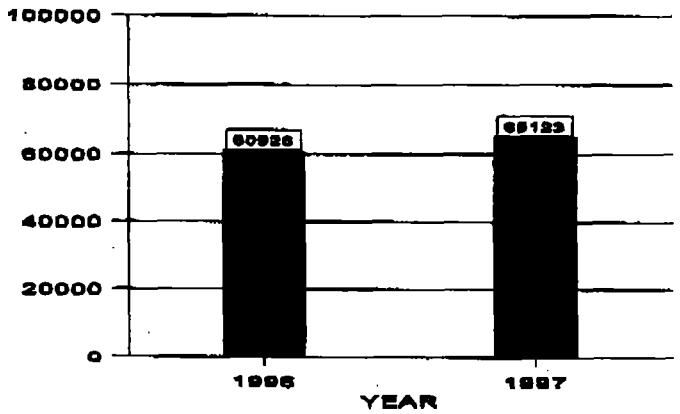
At the Same Time, Ombudsman Complaints Increased from 1989 to 1994



Beginning in 1996, a new Ombudsman reporting system was used that counted complaints differently from the prior system. Data from 1996 and 1997 also show that complaints increased seven percent between these two years, from 60,926 to 65,123, as illustrated in Graph C below.

Graph C

Ombudsman Complaints Also Increased from 1996 to 1997



Ombudsman complaints about resident care have been particulary prevalent. Of the five

main Ombudsman complaint categories, the resident care category increased the most from 1996 to 1997, growing by 13 percent. This category includes specific complaints about personal care (such as pressure sores and hygiene), lack of rehabilitation, and the inappropriate use of restraints. On a more specific level, 12 complaints had increases of 24 percent or more from 1996 to 1997. Two of these - staff turnover and lack of staff training - may indicate other problems with resident care.

In 1997, the majority of all Ombudsman complaints (63 percent) fell into 2 of 5 categories - resident care (32 percent) and residents' rights (31 percent). The top 10 complaints for that year include 3 related to inadequate nursing home staffing, as well as specific complaints about poor quality of care, such as poor hygiene, physical abuse, and improper handling and accidents.

Resident abuse complaints. Data obtained from nursing home abuse complaint coordinators in the 10 sample States lack common definitions and are therefore inconsistent. Furthermore, these complaints are not always substantiated. Among the 10 States, there are no obvious trends in reported complaints; some States have upward trends and others downward trends. Nevertheless, approximately one percent or more of nursing home residents in the 10 States have had an experience serious enough to register an abuse complaint.

Additionally, since 1995 the OIG has excluded 668 nursing home workers from participation in the Medicare/Medicaid programs as a result of a conviction related to patient abuse or neglect. The excluded workers were primarily nurses and nurse aides.

Chronically substandard homes. Some nursing homes appear to be chronically substandard. Data from OSCAR show that some are repeatedly deficient; 463 nursing homes have been cited with the same deficiencies over the past four contiguous surveys, representing 6 percent of all homes in the 10 sample States. State directors and surveyors also report that between 1 to 20 percent of nursing homes in their State have chronic quality of care problems. Finally, three-fourths of Ombudsmen say there are some homes (10 percent or fewer) that routinely treat residents poorly.

Insiders' perspectives. Survey and certification staff and Ombudsmen express some reservations about relying exclusively on program data to identify nursing home problems. While generally satisfied with OSCAR data, more than half of State directors and surveyors believe it is not a true indicator of nursing home quality of care since it only portrays the situation of the nursing home at the time surveyors are physically conducting the survey. Ombudsmen also say that higher complaint rates do not always indicate more problems, pointing out that higher complaint rates could be due to a greater presence of Ombudsman staff in nursing homes.

Nevertheless, in all 10 sample States, State survey directors, State and local Ombudsmen, and State Aging Unit Directors confirm that problems with care persist in nursing homes.

These are many of the same problems reported in program data. Most surveyors mention that nursing home staffing shortages and inferior staff proficiency levels precipitate chronic quality of care in nursing homes. They also mention resident abuse, failure to treat incontinent patients, and improper medication distribution. Ombudsmen say the problem they see most frequently in nursing homes is inadequate nursing home staff. They additionally identify malnutrition and other dietary concerns, bed sores, dehydration, poor hygiene, over-medication, toileting, and physical abuse as problems nursing home residents face.

Survey and certification agencies are following required standard protocols but weaknesses in the survey system itself limit their effectiveness

State survey and certification agencies monitor nursing home care with timely and standard surveys, complaint procedures, and additional State processes. Based on OSCAR data over the last 4 standard surveys, all sample States completed 97 percent of their standard surveys in the mandated time frame of 9 to 15 months. Furthermore, all State survey directors and surveyors report following HCFA guidelines for their surveys, including starting with an entrance conference, touring the facility, interviewing residents and family members, reviewing medical records, and concluding with an exit conference. They also report having a complaint process to address complaints about nursing home practices. Seven States have their own survey guidelines which they use in addition to HCFA guidelines, and some have additional databases and information sources.

Despite following standard procedures, however, the survey and certification system has several weaknesses, including the predictability of surveys. Although all States use unannounced nursing home surveys, almost all directors and surveyors believe that facilities can anticipate the survey start date. They say that facilities often modify their normal daily procedures to reduce potential deficiencies, such as increasing staff on certain shifts. In most States, surveyors also do not begin or continue standard surveys on the weekend or in evening hours. State directors and surveyors therefore voice concerns about whether standard surveys represent an accurate reflection of quality of care in nursing homes.

The survey and certification process is also limited by weak enforcement, including inaction on abuse complaints. From January 1997 to July 1998, OSCAR data reports 4,707 abuse complaints (involving almost one third of nursing homes) in the 10 sample States. Two-thirds of these were unsubstantiated and the remaining third were substantiated. Over 90 percent of both substantiated and unsubstantiated complaints concluded with no action, plans of correction, or other remedy. Furthermore, half of the State directors and three-fourths of surveyors indicate that current enforcement measures are questionable. They express concern that civil monetary penalties do not compel nursing homes to observe Federal regulations, are insufficient to influence nursing home

chains, and are not imposed immediately, allowing facilities to remain non-compliant for longer periods of time. Others believe that current enforcement process allows deficient facilities far too many opportunities to avoid enforcement action.

Finally, survey and certification agencies have a number of staffing constraints. The overall number of surveyors varies by State, thereby affecting the number of standard, follow-up, and complaint surveys each team can conduct. For example, the number of standard surveys on the 10 States ranges from 12 to 26 per year. State directors also express concern about high staff turnover rates, difficulties replacing staff once they leave, and limited surveyor training. They additionally report weaknesses in coordination between their staff and Ombudsman staff. Surveyors received only 13 percent of all Ombudsman abuse complaints per month in 1997.

While the Ombudsman program is well designed, inadequate resources limit its capacity

The Ombudsman program has several functions to promote and monitor quality of care in nursing homes, including identifying and resolving complaints, making regular visits to nursing homes, and engaging in a variety of different advocacy activities. Discussions with State and local Ombudsmen, as well as State Aging Unit Directors, emphasize the uniqueness of this program. In contrast to other programs, Ombudsmen lack enforcement and regulatory oversight authorities. As independent advocates, they work solely on behalf of residents and are often the only voice residents have in their own care. An ongoing, routine nursing home presence is therefore essential to the Ombudsman role. In fact, most State Ombudsmen (6 of 10) believe this presence is the most important part of their program. This presence provides Ombudsmen with the opportunity to develop personal and confidential relationships with residents and enables them to identify and address individual issues before they become larger, systemic problems.

Nevertheless, the overall capacity of the Ombudsman program is limited by inadequate resources, including inadequate staffing. Paid staffing and volunteer levels among the 10 States vary considerably, ranging from 4,618 nursing home beds per paid staff in one State to 1,115 beds per paid staff in another. While no minimum staffing ratios are required by law, a 1995 Institute of Medicine study on the Ombudsman program recommends a standard staffing ratio of 1 paid Ombudsman staff person per 2,000 long term care facility beds; only 1 of the 10 sample States, Massachusetts, meets this standard. Furthermore, a majority of State and local Ombudsmen identify insufficient program staffing and an inadequate number of volunteers as obstacles which detract from their program's effectiveness.

Inadequate program staffing is particularly evident in the limited extent to which Ombudsmen make regular nursing home visits. In the nine States that make such visits, volunteers are generally assigned to just one nursing home and visit this home on a weekly basis. However, most nursing homes in the 10 States do not have volunteers

assigned to them, and these homes are usually visited by paid staff just once or twice a year for no longer than one to three hours. In fact, in four States there are nursing homes that are never visited by volunteers or paid staff.

Other limitations affect the Ombudsman program's overall capacity. Lacking a common standard for complaint response and resolution, Ombudsman staff in some States are not consistently handling complaints in a timely manner. Ombudsman staff also devote varying amounts of time to outreach and advocacy activities, with some spending relatively little time on community education, work with the media, work on laws and policy, and nursing home staff training. Also, half of State and local Ombudsmen believe their program's lack of support in the State diminishes its capacity and limits their ability to influence nursing home policies. Lastly, they believe better collaboration is needed with the survey and certification agency.

State systems to safeguard nursing home residents from abuse are inconsistent and unreliable

Based on findings from a recent OIG audit, "Safeguarding Long Term Care Residents," (A-12-97-0003) it appears that some weaknesses exist in State efforts to safeguard nursing home residents from abuse. This audit revealed great diversity in the way States systematically identify, report, and investigate suspected abuse. While no Federal requirement exists for criminal background checks of nursing home staff, 33 States do mandate that such checks occur. However, the methods used to identify individuals who pose a risk of abuse and the criteria followed for prohibiting employment vary widely among these States. Furthermore, not all States systematically report convictions to central databases, such as the certified nurses aide registry. It therefore appears that there is no assurance that individuals who may pose a risk to residents are systematically identified and barred from nursing home employment.

A more in-depth audit of Maryland also found problems with nursing home hiring practices in that State. In particular, this audit found that five percent of employees in eight nursing homes had criminal records. It also noted that some of these individuals were not reported in the State or Federal systems used for criminal background checks, despite the fact that they had been convicted of elder abuse.

New initiatives based on law enforcement approaches are being developed

Recent initiatives to strengthen nursing home law enforcement are relatively new. Particularly noteworthy is the formation of nursing home task forces at the local, State and national levels, comprised of representatives from the Department of Justice, HCFA, OIG, and other agencies. These groups will examine and develop action plans for several enforcement strategic areas and will address the full range of nursing home enforcement

issues. They will collaborate with Medicaid Fraud Control Units, the State Attorneys General, State survey agencies, and other oversight agencies. Among the strategic areas targeted are: improving the handling of civil monetary penalty referrals; reviewing patient abuse and neglect legislation for model State legislation; recommending possible new legislation for prosecuting abuse and neglect; reviewing current services available to abuse victims; and identifying emerging quality of care and fraud problems in nursing homes.

By targeting key strategic areas and coordinating among the various agencies responsible for nursing home enforcement, these initiatives appear promising. If successful, they should strengthen enforcement of nursing home problems. However, it is too soon to determine the full impact of these enforcement initiatives. Some of the task forces and action plans will not be developed until early 1999, and at the earliest, preliminary results will not be available until later in that year.

Nursing home reforms established by OBRA 1987 have not been systematically assessed

The nursing home reforms created by OBRA 1987 impacted both nursing home systems and nursing home care. First, these reforms essentially changed the focus from a nursing home's *ability* to provide care to the *quality* of the care actually provided. The OBRA 87 requires nursing homes participating in Medicare and Medicaid to comply with extensive standards. These standards include ensuring various resident rights, rights related to admission, transfer and discharge, and the right to be free from restraints and abuse. The OBRA 87 also requires nursing homes to promote residents' quality of life, conduct periodic resident assessments, and provide the necessary care needed for residents to maintain the highest practicable physical, mental, and psychosocial well-being. Additionally, OBRA 87 requires nursing homes to provide certain services, including nursing, dietary, physician, rehabilitative, dental, and pharmacy services. Finally, several administrative standards were also established, including requirements for nurse aide training, a medical director, and clinical records.

The OBRA 87 also changed nursing home enforcement and survey procedures. Among these changes are: the development of the Resident Assessment Instrument (RAI), which is a standardized assessment instrument for nursing home residents; a more outcome oriented survey that emphasizes gathering information by observing and interviewing residents; and new intermediate enforcement remedies that augment existing options for noncompliant nursing homes.

While it has now been more than a decade since OBRA 1987 was first passed, there has been no systematic assessment of its extensive agenda and no methodical evaluation of whether or not the reforms it intended are actually working. In its 1998 Report to Congress, HCFA attributes positive changes in the use and outcomes of resident assessment instruments and psychopharmacological medications to OBRA 87. The

HCFA also concludes that new enforcement and survey regulations have been effective. Other studies have addressed additional OBRA reforms, including OIG reports on nursing home prescription drug use and resident abuse. Furthermore, data from survey and certification and Ombudsman reporting systems suggest the OBRA requirement that residents be free from restraints is having some effect: deficiencies on restraints and Ombudsman restraint complaints have been decreasing over the past several years. Nevertheless, the success of this major legislation has not yet been established. A definitive assessment of the extent to which OBRA reforms have bettered conditions in nursing homes is therefore needed.

AN AGENDA FOR CONTINUING IMPROVEMENT IN NURSING HOME CARE

Since OBRA 1987 was first passed, real improvements have been made in nursing home care. More recently, considerable attention has been paid to addressing persisting concerns about nursing home conditions and systems. In particular, we commend the Health Care Financing Administration (HCFA) for its extensive nursing home initiative since it addresses many of these persisting problems. This initiative includes many individual action items which should result in positive changes.

In addition to what HCFA has already initiated, we are suggesting additional steps to be taken to improve nursing home care. These specific recommendations have been made in recently completed OIG reports. They include:

- enhancing survey and certification staffing and training;
- strengthening the Ombudsman program with increased resources;
- improving nursing home staffing levels, and;
- improving coordination between State survey agencies and Ombudsmen.

We also believe that further evaluation and progress measurement would make an important contribution to efforts to advance nursing home care. We specifically suggest:

- a systematic assessment of OBRA 1987 and
- the creation of a national annual report card on conditions in nursing homes.

We have incorporated action items from HCFA's nursing home initiative, recommendations for additional steps to be taken, current OIG work, and areas requiring further evaluation into one comprehensive, long term agenda to continue improvements in nursing home care. This agenda consists of a three stage approach of immediate action, research and evaluation, and continued progress measurement. It is outlined below.

I. Immediate Action

We believe immediate action should be taken to strengthen the capacity of systems designed to oversee nursing home care. We also believe improvements should be made in nursing home staffing levels, since this directly impacts on the care residents receive.

Survey and Certification	
Survey enforcement efforts. Strengthen survey enforcement efforts by: making surveys more timely, effective, and unpredictable; increasing the number of night and weekend surveys and surveys at chronically substandard homes; focusing on specific problems, such as pressure sores; eliminating grace periods for homes with repeat serious violations; proposing new civil monetary penalties; and placing survey results on the internet.	Addressed in HCFA initiative
Enhanced monitoring. Enhance monitoring of special focus facilities.	Addressed in HCFA initiative.
Surveyor training. Provide additional training and assistance to State surveyors.	Partially addressed in HCFA initiative
Surveyor staffing. Evaluate State surveyor staffing to assure adequate staffing is available.	Not currently addressed
Surveyor coordination. Provide a forum for surveyors to meet and discuss common issues.	Not currently addressed
Abuse. Add survey task to look at provider's abuse intervention system, develop national abuse intervention campaign, and promote prosecution of egregious violators.	Addressed in HCFA initiative
Ombudsman Program	
Visibility. Develop guidelines for minimum levels of Ombudsman program visibility, including criteria for frequency and length of regular visits and staffing ratios.	Not currently addressed
Volunteers. Formulate strategies for recruiting, training, and supervising more Ombudsman volunteers.	Not currently addressed
Complaint response and resolution. Develop guidelines for Ombudsman complaint response and resolution times.	Not currently addressed
Reporting system. Continue to refine and improve the Ombudsman program's data reporting system.	Not currently addressed

Coordination with Survey and Certification. Establish ways to enhance coordination between survey and certification and Ombudsman programs.	Not currently addressed
Resident Abuse Safeguards	
Employment safeguards. Improve the safety of residents and strengthen safeguards against employment of abusive workers.	Addressed in HCFA initiative
Nursing Home Staffing	
Staffing standards. Develop staffing standards for registered nurses and certified nurse assistants in nursing homes to assure sufficient staff on all shifts to enable residents to have proper care.	Not currently addressed
Care Guidelines	
Malnutrition and dehydration. Develop best practice guidelines for malnutrition and dehydration care and national campaign to increase awareness of these problems.	Addressed in HCFA initiative
Drug usage. Develop guidelines and protocols for using effective drugs.	Addressed in HCFA initiative

II. Research and Evaluation

We also propose the development of a research and evaluation program to assess the quality of care in nursing homes, including a systematic look at each of the legislative reforms established with OBRA 1987 and other quality of care issues. In the following table, we indicate where the OIG is conducting or planning work. As the Office of Inspector General, we have a particular interest in assuring that the standards mandated by OBRA 1987 are being met. Since we do not expect to address all of the nursing home requirements and issues we have identified, we invite others to join us in this evaluation.

OBRA 1987	
Resident assessment. Determine the systems used by nursing homes to conduct periodic resident assessments and plans of care and evaluate how this impacts reimbursement.	OIG study underway
Nurse aide training. Evaluate nurse aide training	In OIG workplan
Abuse reporting. Examine the extent to which States have implemented abuse reporting requirements.	In OIG workplan
Medical director. Examine the role medical directors play in assuring quality of care.	In OIG workplan

Resident rights. Assess the extent to which nursing homes are assuring resident rights.	
Admission rights. Assess the extent to which nursing homes are assuring admission, transfer, and discharge rights.	
Restraints and abuse. Assess whether rights to be free from restraints and abuse are being met.	
Quality of life. Assess whether or not nursing homes are providing care which promotes each resident's quality of life.	
Resident well-being. Determine if nursing homes are providing care and services to maintain the highest levels of residents' physical, mental, and psychosocial well-being.	
Nursing home services. Determine if nursing home staffing levels are adequate to provide required nursing, dietary, physician, rehabilitative, dental, and pharmacy services.	
Physical environment. Determine if nursing homes are maintaining a healthy and safe physical environment.	
Other Quality of Care	
Resident satisfaction. Determine the level of resident satisfaction with nursing home care.	OIG study underway
Immunizations. Examine the obstacles to immunizing 80% of nursing home residents against pneumoccocal disease and influenza.	OIG study underway

III. Progress Measurement

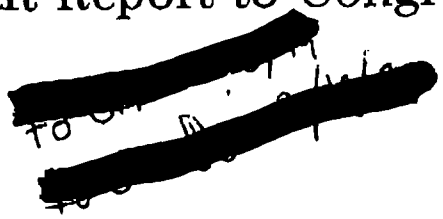
Finally, an independent, continuous assessment is needed to measure the progress made in raising the standard of nursing home care.

Annual Assessments	
Annual report card. Conduct annual evaluations describing conditions in nursing homes based on deficiency trends, Ombudsman complaints, and insiders' perspectives.	Under consideration by OIG

United States General Accounting Office

GAO

Draft Report to Congressional Requesters



NURSING HOMES

Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards

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GAO/HEHS-99-46

OUTLINE

B-XXXXXX

March 22, 1999

Congressional Requesters

The nation's 1.6 million nursing home residents are among the sickest and most vulnerable groups in the population. The federal government, which is projected to pay nearly $39 billion for nursing home care in 1999, plays a key role together with states in assuring that residents receive adequate quality of care. The federal government sets standards that homes must meet to participate in the Medicare and Medicaid programs, and it has authority to impose sanctions[1] if homes do not meet these standards. In recent years, the Congress has authorized additional sanctions (such as fines) to help ensure that homes maintain compliance with the standards. Since these new sanctions have taken effect, however, concerns have continued to surface about the quality of care some homes provide. For example, we previously reported on weaknesses in federal oversight of nursing home care in California and on systemic survey and enforcement weaknesses nationwide.[2]

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

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

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

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

offices, we also evaluated the extent to which these actions would address any problems we identified.

Our information about the extent of serious deficiencies in compliance with standards came mainly from analyzing HCFA's nationwide database of periodic inspections (called surveys) of nursing homes. Our information about the use of sanctions came mainly from work conducted at four of HCFA's ten regional offices and in four states that collectively account for about 23 percent of the nation's nursing homes.[4] Within these four states, we selected 74 homes for detailed analysis, choosing homes that had been referred to HCFA—often several times—for enforcement action. We were looking primarily to see how sanctions were working when homes had serious or sustained compliance problems. Because the sample was chosen deliberately from among the worst homes, it is not representative of all homes, either in these states or nationwide. We conducted our work between December 1997 and December 1998 in accordance with generally accepted government auditing standards. Appendix I contains a more detailed explanation of our scope and methodology.

RESULTS IN BRIEF

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

Surveys conducted in the nation's 17,000-plus nursing homes in recent years showed that each year, more than one-fourth of the homes had deficiencies that caused actual harm to residents or placed them at risk of death or serious injury. The most frequent violations causing actual harm included inadequate prevention of pressure sores, failure to prevent accidents, and failure to assess residents' needs and provide appropriate care. Although most homes corrected the deficiencies identified in the initial survey, subsequent surveys

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

show that problems often returned. About 40 percent of the homes that had such problems in their first survey during the period we examined (July 1995 to October 1998) had them again in their last survey during the period.

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

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

information system. The system in place is ineffective at providing comprehensive information needed to identify homes with recurring problems, homes owned by chains, and deficiencies identified as a result of complaint investigations rather than standard surveys.

We are making several specific recommendations to the Administrator of HCFA to strengthen its enforcement process and thus increase the protection provided to nursing home residents.

BACKGROUND

Nursing homes play an essential role in our health care system. They care for persons who are temporarily or permanently unable to care for themselves, but who do not require the level of care provided in an acute care hospital. Titles XVIII and XIX of the Social Security Act establish minimum standards that all nursing homes must meet to participate in the Medicare and Medicaid programs. Participating nursing homes are required to comply with all of them.[5] Many homes are able to comply with most standards. If homes do not comply, they may be subject to sanctions.

Oversight Is a Shared Federal and State Responsibility

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

[5] Medicare and Medicaid: Requirements for Long Term Care Facilities, Final Rules as published in the Federal Register, Sept. 26, 1991, page 48827.

licensed nursing homes, including those with Medicare certification, and check for compliance with these licensure requirements during standard surveys. States also conduct surveys in response to complaints.

Enforcement of Medicare and Medicaid standards is likewise a shared responsibility. HCFA is responsible for enforcing standards in homes with Medicare certification--about 85 percent of all homes.[6] When homes are found to have deficiencies at the most severe level, or when homes fail to correct deficiencies in a timely manner, HCFA policies call for states to refer these cases to HCFA, together with any recommendations for sanctions. HCFA normally accepts these recommendations but can modify them. States are responsible for enforcing standards in homes with only Medicaid certification--about 14 percent of all homes.

1987 Law Shifted Focus of Regulatory Standards and Added Sanctions

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

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

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

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

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

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

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

Particularly with regard to civil monetary penalties, Congress intended that these sanctions create a strong incentive to maintain compliance with federal standards by penalizing homes for their deficiencies. To this end, the associated House Budget Committee Report[8] stated:

[8]House Budget Committee Report H.R. No 100-391(Part I)(1987), p. 473. The Committee's provision establishing Civil Monetary Penalties was adopted in Conference.

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

HHS issued regulations implementing OBRA 87 in two stages. Regulations implementing standards were effective by October 1990, but enforcement regulations covering sanctions did not become effective until July 1995. According to a HCFA official, publication of enforcement regulations was delayed because of the controversial nature of the regulation and the workload associated with responding to the large volume of comments received in the rulemaking process.

Sanctions Are Matched to Severity of Deficiencies

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

For each deficiency identified in the survey process, the approach places the deficiency in one of 12 categories, labeled "A" through "L" depending on the extent of patient harm and the number of patients adversely affected (see table 2). The most severe category ("L") is for a widespread deficiency that causes actual or potential for death or serious injury to residents; the least severe category ("A") is for an isolated deficiency that poses no actual harm and has potential only for minimum harm. Homes with deficiencies that do not

exceed the "C" level are considered in "substantial compliance," and as such, providing an acceptable level of care.[10] The effect of HCFA's categorizing is that for a home to be out of compliance, it must have one or more deficiencies that subject a resident to at least the potential for more than minimal harm.

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

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

[a]Group 1 sanctions are directed plan of correction, directed in-service training, and/or state monitoring. Group 2 sanctions are denial of payment for new admissions or all individuals, and/or civil monetary penalties of $50-$3,000 per day of noncompliance.
Group 3 sanctions are temporary management, termination, and/or civil monetary penalties of $3,050-$10,000 per day of noncompliance.
[b]This category is referred to in regulations as "immediate jeopardy."
[c]Sanctions for category I also includes option for temporary management.

The scope and severity grid shown in table 2 also provides the basis for enforcement sanctions. Homes in substantial compliance are not subject to sanctions. For noncompliant

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

homes referred to HCFA for sanction, the severity of the sanction that must or can be imposed generally increases with the severity of the deficiency. Sanctions are divided into three groups as follows: group 1 (directed plan of correction, directed in-service training, and/or state monitoring), group 2 (denial of payment for new admissions or all individuals and/ or civil monetary penalties of $50-$3,000 per day of noncompliance), and group 3 (temporary management, termination, and the option for civil monetary penalties of $3,050-$10,000 per day of non-compliance). For each step in the severity grid, a sanction from a particular group must be imposed, and sanctions from certain other groups can be added.[11] For example, a home with one or more deficiencies rated "J" or higher must receive a sanction from group 3, and HCFA has the option of levying additional sanctions from groups 1 or 2. HCFA regulations provide that that the choice of sanctions is to take into account not only the severity and scope of the deficiency but also a consideration of prior performance, desired corrective and long-term compliance, and the number and severity of all the home's deficiencies together.

Under their shared responsibility for Medicare-certified nursing homes, state agencies identify and categorize deficiencies, and make referrals with proposed sanctions to HCFA. States do not impose federal sanctions. HCFA is responsible for imposing sanctions and collecting monetary penalties.

States May Grant Noncompliant Homes A Grace Period

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

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

with repeat severe deficiencies. HCFA policies call for states to refer these homes immediately for sanction.

HCFA also requires for a notice period between when a sanction is imposed and when it takes effect. When HCFA regional offices receive referrals from the states, they review the case and the state's recommendation, decide whether to impose a sanction, and notify the home if a sanction is imposed. HCFA regulations provide a 15-day period for this home to come into compliance, and if a home does so by the deadline, the sanction does not take effect. There are two major exceptions. One is a civil monetary penalty, which can be assessed retroactively even if a home corrects the problem. The other is when a nursing home is found to have a deficiency rated "J", "K", or "L". In this circumstance, HCFA may impose a sanction after a 2-day notice period.

MANY NURSING HOMES HAD DEFICIENCIES THAT HARMED RESIDENTS

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

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of the survey, it must be terminated from Medicare and Medicaid.

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

One-fourth of All Homes Had Deficiencies In Highest Severity Categories

Compliance with nursing home standards of care continued to be a problem during the entire 3-year period we examined. Our analysis of the first and last sets of surveys for each home conducted during this period[13] showed little overall change in the number of cited deficiencies per noncompliant nursing home (3.79 deficiencies in the base period and 3.74 in the last survey) or in the severity of these deficiencies. In the earliest set of surveys conducted after July 1995, 28 percent of homes had at least one deficiency in the two highest-severity categories (actual or potential for death or serious injury and other actual harm); in the last set of surveys, the figure was 27 percent (see table 3).[14]

Table 3: Base Period and Ending Period Survey Deficiencies

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

[a]First survey conducted between July 1, 1995, and December 31, 1996
[b]Most recent survey conducted between January 1, 1997, and October 22, 1998

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

[14]There was also little change in the proportion of deficiencies within each severity level.

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

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

Number of Homes Cited	Deficiency Category	Health Effect of Deficiencies
2,809	Inadequate attention to prevent pressure sores.	Pressure sores are painful areas of the skin and underlying tissue, which erode as a result of pressure, friction, or lack of blood supply. The severity can range from skin redness to large wounds which can expose skin tissue and bone. With consistent care and attention, most sores can be prevented or made less severe. Without proper care, complications of pressure sores include pain, infection, increased debilitation, and skin loss with extensive destruction or damage to muscle and bone.
1,857	Failure to provide supervision or assistance devices to prevent accidents.	Many nursing home residents are vulnerable to accidents, but bed bound residents are at the highest risk for falls because they may try to get out of bed on their own, and fall, which often results in serious injury such as hip fracture. With appropriate supervision and accident prevention devices, such as alarm devices or external hip protectors, accidental injury that occurred might have been prevented.
2,158	Failure to provide comprehensive assessment of resident needs. Poor development of care plans. Failure to provide necessary care to attain the highest level of well-being.[b]	The quality of care that a resident receives is largely dependant on assessment of their needs, and developing and following the plan of care developed to meet these needs. For example, resident assessments should identify individual needs, such as urinary or bowel continence, and these needs should be matched with a plan, such as 'the resident will be assisted to the bathroom every three hours'. At regular intervals, the health care team is supposed to develop objectives for the highest level of functioning and well-being a resident may be expected to attain, such as 'the resident will remain continent at all times'.
1,171	Failure to maintain acceptable nutritional status.	Facilities must ensure that residents receive sufficient nutrition to maintain body weight (unless a resident's condition makes this impossible). Poor nutritional status can lead to increased rates of infection, cognitive impairment, and premature mortality.
555	Failure to provide appropriate treatment for incontinent resident.	Residents should be provided adequate incontinent care. If left unattended, incontinence can lead to serious physical complications including infection, skin breakdown, and sepsis, as well as emotional damage to resident dignity.
510	Failure to maintain or enhance resident's dignity.	HCFA regulations protect and promote the right of each resident to a dignified existance. Accordingly, HCFA policies stipulate that nursing homes must assist residents to be well-groomed, promote resident independence, respect resident privacy, and focus on residents as individuals. Such uncaring

Number of Homes Cited	Deficiency Category	Health Effect of Deficiencies
		acts as allowing a helpless resident to be physically exposed to visitors and other residents, or being verbally abusive to a resident are violations of a resident's dignity.
421	Improper use of physical restraints.	Physical restraints, such as cotton vests that can be tied to a chair to prevent the resident from slipping, are devices to restrict freedom of movement and are used to protect residents from injury. Restraint devices cannot be easily removed by residents and improper use can cause decreased muscle tone, increase likelihood of falls or other accidents, incontinence, pressure ulcers, depression, confusion and mental deterioration.
385	Failure to provide proper treatment and services for residents with limited range of motion.	Wheelchair or bed bound residents need assistance with physical movement, because the lack of physical exercise can lead to a loss of function, or 'range of motion', in the fingers, wrists, elbows, shoulders, hips, knees and ankles. A decline in a resident's physical range of motion can result in arm and leg contractures, and further pain, debilitation and immobility.

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

[b] We combined these three deficiencies because of their close link. (1) Resident assessments provide the information necessary to (2) set treatment objectives and care plans to achieve (3) the highest level of functioning and well-being a resident may be expected to attain.

Forty Percent of Homes With Severe Deficiencies Were Repeat Violators

Although it is important to note that most noncompliant homes eventually returned to compliance, many did not maintain this status. Among those homes cited for deficiencies at the two highest levels of severity during the base survey, 39 percent were cited for deficiencies at the same or higher level of severity during the last survey. In other words, 4 of 10 homes that were found by the base survey to have caused actual or potential death or serious injury or other actual harm to residents had deficiencies (possibly different deficiencies) that were just as severe—or worse—in the last inspection during this 3-year period. Although we focused our analysis on deficiencies in the most severe categories, we also noted that among those homes with deficiencies considered to hold potential for more than minimal harm, about 77 percent of the homes out of compliance in the first survey were cited for deficiencies (again, possibly different ones) at the same or higher level of severity during the most recent survey.

APPLICATION OF SANCTIONS DOES NOT ENSURE NURSING HOMES MAINTAIN COMPLIANCE

To determine what role sanctions were playing in bringing about a greater degree of compliance, we focused on our more specific sample of 74 homes that had been referred for sanctions.[15] The case histories of these homes showed that sanctions helped bring the homes back into temporary compliance but provided little incentive to keep homes from slipping out of compliance once again. While several aspects of the sanction program, such as civil monetary penalties, have potential to provide the necessary incentive to better

[15]Based on regional enforcement records, we estimate that since July 1995 about 12 percent of noncompliant homes in the four states we visited were referred to HCFA for possible sanction.

ensure continued compliance, certain HCFA policies or practices limited their effectiveness with these homes.

Most Sanction Activity Achieved Corrective Action But Not Continued Compliance

The 74 homes we reviewed had been referred by the states to HCFA for possible sanctions a total of 241 times—on average, about three times each. All 74 homes also had at least one deficiency that caused actual harm to residents or placed residents at risk of serious injury or death. Some referrals were accompanied by a recommendation for one sanction, while others were accompanied by recommendations for two or more. The most common sanction ultimately imposed by HCFA was denial of payments for new admissions, which was imposed a total of 176 times. HCFA imposed 115 civil monetary penalties and 44 terminations.

Table 5: Disposition of Referrals for the 74 Homes in GAO's Review

	Denial of payment for new admissions	Civil monetary penalties	Termination
Number of sanctions imposed by HCFA[16]	176	115	44
Number in which sanctions never took effect	97	78	31

When a sanction was imposed, the home generally corrected its deficiencies, and when it did, HCFA rescinded the sanction. For example, as table 5 shows, denial of payment never took effect in 97 of the 176 instances in which it was imposed. This usually occurred because the facility corrected the deficiency before the effective date of the sanction.[17] The

[16] HCFA policies call for a 15-20 day notification period between when denial of payment or termination are imposed and when they take effect.. Accordingly, these notices served as the basis for the number of sanctions that were actually imposed for these categories.

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

ability of sanctions to help bring about corrective action is reflected in the fact that, at the time of our study, only 4 of the 13 homes in our sample that were terminated ultimately failed to comply and remained terminated from the Medicare and Medicaid programs.

Although sanctions—or the penalties they carry—helped induce the homes into taking action to correct identified deficiencies, many of the homes were again out of compliance by the time the next survey or follow-up inspection was conducted. Of the 74 homes we reviewed, all but five had again been referred for sanctions after being found out of compliance once more; some went through this process as many as six or seven times. Table 6 provides an illustration of some of the cases in our sample where homes had been cited for serious deficiencies, referred to HCFA for sanctions, and subsequently cited for serious deficiencies again.

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

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

higher number of the 115 fines imposed may take effect.

This "yo-yo" pattern of compliance could be found even among homes that were terminated from Medicare, Medicaid, or both. Termination is usually thought of as the most severe sanction and is generally done only as a last resort.[18] Once a home is terminated, however, it can generally apply for reinstatement if it corrects its deficiencies. For three of the nine reinstated homes in our group, the pattern of noncompliance returned. For example, a Texas nursing home was terminated from Medicare for a string of violations that included widespread deficiencies at the severity level of actual harm to residents. About 6 months after the home was terminated, it was readmitted under the same ownership. Within 5 months, state surveyors identified a series of deficiencies involving harm to residents, including failure to prevent avoidable pressure sores or ensure that residents received adequate nutrition.

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

Manner In Which Sanctions Are Being Implemented Hampers Their Effectiveness

Sanctions are having a limited effect on ensuring continued compliance because sanctions and procedures directed toward continued compliance are not being used effectively. We identified three aspects of the sanction program that had particular applicability to helping ensure that homes maintained compliance rather than slipping into a pattern of temporary compliance followed by subsequent noncompliance. We found problems in the way in

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

which all three were being implemented. Civil monetary penalties, the sanction with the greatest potential deterrent effect, were hampered by a growing backlog of appeals. Imposing sanctions without a grace period was seldom used because of restrictive HCFA guidance. And termination, the ultimate sanction because it removes homes from the program, had little effect because many homes were able to reenter the program with little consequence for their past actions and a "clean slate" for the future.

Civil Monetary Penalties Provide Deterrence But Are Hampered by Appeals Backlogs

Civil monetary penalties have an advantage in encouraging homes to remain in compliance: they can be applied retroactively to the date of initial noncompliance (they cannot be avoided simply by taking corrective action) and the longer the deficiency remains, the larger the penalty can be. When the new sanctions were put in place, HCFA's initial enforcement policies had provisions for making wide use of such penalties. HCFA has since modified its policy by reserving civil money penalties for more serious deficiencies ("G" or higher in the enforcement grid).

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

In two of the four states we visited, large backlogs undermined the effectiveness of the sanction. Backlogs do so in two main ways. First, they increase the pressure on HCFA to resolve the appeal by negotiating settlements—a strategy that helps somewhat in controlling the growth of the backlog but can also lower the size of the fine.[19] Second, even if the appeal goes to a hearing and a penalty is upheld, the home has gone considerable time without having to pay. As a result, it is not surprising that some owners routinely appeal imposed penalties. For example, regional enforcement logs disclosed one large Texas nursing home chain appealed 62 of the 76 civil monetary penalties imposed on its nursing homes (including chain-owned homes that were not in our sample) between July 1995 and April 1998. These 62 penalties totaled $4.1 million.

Some Procedures Limit Ability to Impose Immediate Sanctions

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

Until September 1998, HCFA's definition of a poorly performing home was so narrow that it excluded many nursing homes that had repeated deficiencies causing actual harm to residents. In our earlier report on California nursing homes, we found that 73 percent of homes cited repeatedly for harming residents did not meet HCFA's definition of a poorly

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

performing facility. In the other states we visited we also found instances of severe and repeated deficiencies that were not designated as poor performers and thus avoided immediate sanctions.

HCFA has since revised its definition to broaden the circumstances under which a nursing home could be designated as a poorly performing facility. The new definition includes homes with any deficiencies rated "H" or higher in the scope and severity grid (see table 2) on its current survey and in its previous standard survey or any intervening survey (including complaint investigations). HCFA said it would expand the definition in 1999 to include deficiencies in category "G."

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

A second area—and one that HCFA has not addressed—involves referral of homes cited for deficiencies that contributed to the death of a resident. We found several examples where state surveyors cited the deficiency during a complaint investigation that took place some time after the incident, and found that the deficient practice contributing to the death had ceased at the time of the investigation. Under HCFA policy, such deficiencies corrected at the time of the investigation are considered "past noncompliance" and are to be cited as isolated actual harm, level "G" in HCFA's scope and severity grid (see table 2). HCFA does not require homes with level "G" deficiencies to be referred for sanctions. As a result, homes cited for deficiencies so severe that they contribute to a resident's death may not be referred to HCFA for sanctions at all. By allowing these homes to escape immediate sanction, much of the ability to deter future noncompliance is lost. Table 7 shows examples of homes that were not referred for immediate sanction.

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

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

After Readmission, Terminated Homes Receive a "Clean Slate" But Continue Old Behaviors

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

spotty performance we found among those homes in our sample that had been terminated and subsequently reinstated, this policy merits reexamination.

Two other aspects of HCFA's use of termination also limit its effectiveness. First, HCFA typically paid terminated homes in our sample for 30 days after termination regardless of whether transfers of patients were under way.[20] This policy in effect gives terminated homes 30 extra days of payment while they seek reinstatement. Second, HCFA generally used a short "reasonable assurance period[21]" to determine if homes seeking reinstatement to Medicare had corrected their problems and were otherwise complying with the standards. HCFA can make this period last up to 180 days, but the homes we examined were generally reinstated within a reasonable assurance period of 30 to 60 days. A shorter period provides less assurance that homes can sustain long-term compliance.

DESPITE RECENT HCFA PROPOSALS TO MAKE SANCTIONS MORE EFFECTIVE, ADDITIONAL STEPS ARE NEEDED

Recent actions taken or proposed by HCFA to improve nursing home oversight can help make sanctions more of a deterrent against continued noncompliance, but on their own they are not enough to fully address the problems we identified. HCFA began a series of actions in response to our earlier report on California nursing homes and its own July 1998 report to the Congress summarizing a 2-year study of nursing home regulation.[22] These actions

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

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

[22] Report to Congress: Study of Private Accreditation (Deeming) of Nursing Homes,

address a number of problems we identified in our earlier report, but do not resolve additional problems we have identified through our ongoing work. Further, weaknesses in HCFA's management information systems will continue to limit its ability to implement its initiatives and further strengthen its enforcement processes.

HCFA Initiatives Leave Problem Areas Unresolved

In July 1998, HHS announced several actions that HCFA would take to toughen enforcement of nursing home regulations, particularly focusing on homes with serious and repeat deficiencies. The actions include plans to expand the definition of "poorly performing facility" to include more homes with repeat deficiencies that harmed residents. HCFA also directed that the results of complaint investigations be considered in determining whether a home should be designated as "poorly performing". The actions also called for increased survey frequency for homes with the most chronic compliance problems and focusing enforcement efforts on nursing homes in chains that have a record of noncompliance with federal rules. With regard to the problems we have identified in this report, however, HCFA's actions leave several issues unresolved. HCFA may be able to resolve one of the issues (the backlog of civil monetary appeals) if its plan for additional staff positions is adopted. However, there are not actions underway with regard to the other issues—referring homes for sanction in all cases where deficiencies contributed to the death of a resident, and better using the deterrent effect of termination from the Medicare and Medicaid programs (see table 8).

Regulatory Incentives and Non-Regulatory Initiatives, and Effectiveness of the Survey and Certification System, Health Care Financing Administration, July 1998

Table 8: Sanction-Related Problems Remaining After Recent HCFA Initiatives

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

HCFA initiatives also include a proposal to allow civil monetary penalties to be assessed on instances of noncompliance as an alternative to the number of days out of compliance. Since the proposed regulation had not been issued as of February 1998, when we were completing our review, we were not able to evaluate the extent, if any, that it could have on increasing its use.

Management Information Systems Have Limited Ability to Support Key HCFA Initiatives

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

In regard to the first of these weaknesses, HCFA lacks a system that integrates federal and state enforcement information to help ensure that homes receive appropriate regulatory attention. Such a system would track key information about steps taken by HCFA offices and the states, such as verification that deficiencies were corrected, or sanctions imposed. Although HCFA has a computer system for this purpose--the Online Survey, Certification, and Reporting (OSCAR) system--none of the HCFA regions or the states that we visited were using it to monitor enforcement actions. Information in OSCAR was incomplete and inaccurate because states and HCFA did not consistently enter data into the system. As a result, they all maintained their own unique systems. At the time of our initial inquiry, HCFA regional systems ranged from manual paper-based systems to complex computerized programs. The four states we visited also maintained their own tracking systems. None was compatible with OSCAR or the regional office tracking systems.

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

A second area in which HCFA lacks adequate information is the results of complaint surveys. HCFA does not require states to cite violations of federal standards if the deficiencies were found during complaint surveys, or ensure that if such deficiencies are cited, they are reported to HCFA. One of the four states we reviewed based their decisions to refer homes to HCFA for sanctions only on the results of the annual surveys.[23] California did not report the results of complaint investigations to HCFA, instead choosing to deal with the homes under the state's licensing authority. These practices leave HCFA without full information about nursing homes' compliance status with Medicare and Medicaid standards. In September 1998, HCFA modified its guidance to states to stipulate that any federal deficiencies cited during complaint investigations must be used in determining if a nursing home is a "poorly performing facility".

The situation in one state we visited (California) shows how this lack of information limited HCFA's ability to get a full picture of a home's compliance with Medicare and Medicaid standards. California surveyors usually do not cite federal deficiencies when they find violations in complaint investigations.[24] As a result, California does not recommend, and HCFA has no basis to impose, federal sanctions on deficient nursing homes resulting from complaint investigations. In many instances, substantiated complaint investigations disclosed severe deficiencies that were not part of the record referred to HCFA. For example:

- One home had 61 complaints between September 1995 and July 1998. State investigators substantiated violations in 30 of these complaints, some of which resulted in actual harm or placed the resident in immediate danger, such as abuse of a resident by a staff member and failure to prevent or treat pressure sores. The state agency levied fines totaling $80,000 under its own licensing authority but did not cite any federal

[23]HCFA officials told us that some other states, including New York and Louisiana, also do not report results of complaint investigations to HCFA.

[24]California surveyors cite deficiencies and impose fines under state licensing requirements. In June 1998, California changed its procedures to cite federal deficiencies for substantiated complaints, however, the new procedures were not fully implemented as of October 1998.

deficiencies although many of these findings clearly violated Medicare and Medicaid standards. The home's standard surveys did not document major problems. As a result, HCFA remained unaware of this home's compliance problems.

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

To illustrate the impact of this lack of ownership information, we identified a chain provider in one state and linked the three available sources of ownership information: HCFA records, state records, and fiscal intermediary[26] records. The linking showed this chain provider had a disproportionate number of enforcement actions relative to other homes in the same states. In Texas, it owned about 11 percent of the nursing homes but accounted for over 18 percent of the state's enforcement actions, including 25 percent of the state's immediate jeopardy cases and 25 percent of the poorly performing facilities. In Michigan, where the chain owned eight facilities, six of the eight had a total of 27 separate enforcement actions. Despite multiple enforcement actions against these homes, Michigan and HCFA regional officials were unaware that the Michigan homes had a common owner or of the problem history of the owner's facilities in Texas. When we brought the results of our analysis to HCFA officials, they said this was a good example of why information on common ownership was needed. The inability to identify and track homes by chain could pose an immediate limitation on HCFA's recent initiative to direct more enforcement efforts toward

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

nursing home chains. To be successful in this initiative, HCFA needs to ensure that it can identify and track homes with common ownership.

CONCLUSIONS

Despite reforms to ensure that nursing homes maintain compliance with federal quality standards, one-fourth of all homes nationwide continue to be cited for deficiencies that either caused actual harm to residents or carried the potential for death or serious injury. This pattern has not changed since the reforms were implemented almost 4 years ago. Although the reforms equipped federal and state regulators with many alternatives and tools to help promote sustained compliance with Medicare and Medicaid standards, the way in which states and HCFA have applied them appears to have resulted in little headway against the pattern of serious and repeated noncompliance. Such performance may do little to dispel concerns over the health and safety of frail and dependent nursing home residents.

The enforcement system we observed still sends signals to noncompliant nursing homes that a pattern of repeated noncompliance carries few consequences. HCFA's recent actions, such as broadening the definition of a "poorly performing facility," are a step in the right direction. However, four key problems we identified remain in need of attention. First, if the backlog of civil monetary penalties is not reduced, much of the deterrent effect of this sanction will continue to be lost. Second, weaknesses remain in the deterrent effect of termination, including the lack of a tie to "poorly performing facility" status for reinstated homes and the limited "reasonable assurance period" for monitoring terminated homes before reinstating them. Third, under HCFA guidance, states are not required to refer for sanction all homes with deficiencies which contribute to resident deaths. And finally, the changes do not address the need for HCFA to improve its management information system. HCFA's ability to improve its oversight of nursing homes will depend heavily on whether it has the information to identify and monitor those homes that pose the greatest risk of harm.

RECOMMENDATIONS TO THE ADMINISTRATOR OF HCFA

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

- Improve the effectiveness of civil monetary penalties. The Administrator should continue to take those steps necessary to shorten the delay in adjudicating appeals, including monitoring progress made in reducing the backlog of appeals.
- Strengthen the use and effect of termination. The Administrator should (1) continue Medicare and Medicaid payments beyond the termination date only if the home and state Medicaid agency are making reasonable efforts to transfer residents to other homes or alternate modes of care, (2) use longer "reasonable assurance periods" before reinstating terminated homes, and (3) revise existing policies so that the pre-termination history of a home is considered in taking an subsequent enforcement action.
- Improve the referral process. The Administrator should revise HCFA guidance so that states refer homes to HCFA for possible sanction (such as civil monetary penalties) if they have been cited for a deficiency that contributed to a resident's death.
- Develop better management information systems. The Administrator should enhance OSCAR or some other information system that can be used both by the states and by HCFA to integrate the results of complaint investigations, track the status and history of deficiencies, and monitor enforcement actions.

Agency Comments and Our Response

As agreed with your office,

We plan no further distribution of this report until March 22, 1999. At that time, we will make copies of this report available to others upon request.

Please contact me or Kathryn Allen, Associate Director at (202) 512-7114 if you or your staff have any questions about this report. This report was prepared by Margaret Buddeke, Peter Schmidt, Terry Saiki, Stan Stenersen, and Evan Stoll under the direction of Frank Pasquier.

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

List of Requesters

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

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

The Honorable Ron Wyden
United States Senate

The Honorable Nick Smith
House of Representatives

Appendix I

SCOPE, AND METHODOLOGY

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

In addition to analysis of the extent that homes comply with the standards, we used the data to determine the most frequently occurring deficiencies as well as their relative severity.[26] In order to compare nursing homes' performance in achieving and maintaining compliance over time, we used the OSCAR data to identify the earliest recertification survey performed after the regulations became effective compared to the homes most current survey. To do this we used data from a facility's first survey during the period July 1, 1995 to December 31, 1996 which became part of the 'base' period. Data from the latest survey since January 1, 1997 became part of the 'current' period.[27]

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[26]We edited approximately one percent of the OSCAR survey data that had coding gaps. For example, after discussion with HCFA officials we considered that post-1995 surveys that had deficiencies but no scope and severity codes to be at the lowest severity level.

[27]For some nursing homes, there will have been an intervening survey.

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

To determine the extent to which the new sanctions contribute to nursing homes' sustained compliance, we were unable to use HCFA's OSCAR system to perform a similar nationwide analysis. We found that OSCAR does not contain complete or reliable data on enforcement actions, such as the extent that sanctions are imposed, nor does any other system exist that provides nationwide data. For this reason, we instead relied on enforcement monitoring databases from four HCFA regional offices.

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

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

In all, we selected 74 separate nursing home providers. These providers accounted for 241 enforcement actions between July 1995 and October 1998 (see table 9). These enforcement actions consisted of both recertification surveys as well as other abbreviated surveys (follow-up or complaint) surveys where the state had referred cases to the HCFA regional office for sanctions.

Table 9: Nursing Homes Selected for GAO Review

HCFA Region	State	Number of Nursing Homes Reviewed	Number of HCFA Enforcement Actions
III-Philadelphia	Pennsylvania	17	44
V-Chicago	Michigan	18	81
VI-Dallas	Texas	27	96
IX-San Francisco	California	12	20

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

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

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