

California Nursing Homes: Care Problems Persist Despite Federal and State Oversight (Letter Report, 07/27/98, GAO/HEHS-98-202).

Pursuant to a congressional request, GAO reviewed allegations that residents in California nursing homes are not receiving acceptable care, focusing on: (1) examining, through a medical record review, whether these allegations had merit and whether serious care problems currently exist; (2) reviewing the adequacy of federal and state efforts in monitoring nursing home care through annual surveys; and (3) assessing the effectiveness of federal and state efforts to enforce sustained compliance with federal nursing home requirements.

GAO noted that: (1) despite the federal and state oversight infrastructure currently in place, certain California nursing homes have not been and currently are not sufficiently monitored to guarantee the safety and welfare of their residents; (2) GAO reached this conclusion primarily using data from federal surveys and state complaint investigations conducted by California's Department of Health Services (DHS) on 1,370 California homes, supplemented with more in-depth analysis of certain homes and certain residents' care; (3) GAO found that surveyors can miss problems that affect the safety and health of nursing home residents and that even when such problems are identified, enforcement actions do not ensure that they are corrected and do not recur; (4) with regard to allegations made about avoidable deaths in 1993, GAO's expert nurses' review of the 62 resident cases sampled found that residents in 34 cases received care that was unacceptable and that sometimes endangered their health and safety; (5) in the absence of autopsy information or other additional clinical evidence, GAO cannot be conclusive about the extent to which this unacceptable care may have contributed directly to individual deaths; (6) unacceptable care continues to be a problem in many homes; (7) GAO believes that the extent of serious care problems portrayed in federal and state data is likely to be understated; (8) GAO found that homes could generally predict when their annual on-site reviews would occur and, if inclined, could take steps to mask problems otherwise observable during normal operations; (9) GAO found irregularities in the homes' documentation of the care provided to their residents; (10) in visiting homes selected by California DHS officials, GAO found multiple cases in which DHS surveyors did not identify certain serious care problems; (11) surveyors missed these care problems because federal guidance on conducting surveys does not include sampling methods that can enhance the spotting of potential problems and help establish their prevalence; (12) the Health Care Financing Administration's (HCFA) enforcement policies have not been effective in ensuring that the deficiencies are corrected and remain corrected; (13) California's DHS grants all noncompliant homes, with some exceptions, a 30- to 45-day grace period, during which they may correct the deficiencies without penalty; (14) a substantial number of California's homes that have been terminated and later reinstated have soon thereafter been cited again for serious deficiencies; and (15) the problems GAO identified are indicative of systemic survey and enforcement weaknesses.

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Cover

===== COVER

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

July 1998

CALIFORNIA NURSING HOMES - CARE
 PROBLEMS PERSIST DESPITE FEDERAL
 AND STATE OVERSIGHT

GAO/HEHS-98-202

California Nursing Homes

(101700)

Abbreviations

===== ABBREV

ACLAIMS - Automated Certification and Licensing Administrative
 Information Management System
 DHS - Department of Health Services
 HCFA - Health Care Financing Administration
 HHS - Department of Health and Human Services
 OBRA87 - Omnibus Budget Reconciliation Act of 1987
 OSCAR - On-Line Survey, Certification, and Reporting
 UTI - urinary tract infection

Letter

===== LETTER

B-278399

July 27, 1998

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

Nursing homes play an important role in the health care system of the United States. Among other services, they provide skilled nursing and supportive care to older individuals who do not need the intensive medical care provided by hospitals, but for whom receiving such care at home is no longer feasible. An estimated 43 percent of Americans who passed their 65th birthday in 1990 will use a nursing home at some time in their lives. In 1997, there were more than 17,000 nursing homes in the United States with over 1.7 million beds. The federal government, through the Medicare and Medicaid programs, paid these homes nearly \$28 billion in 1997.

In 1997, a lawyer and an investigator raised allegations to your Committee that 3,113 residents died in 971 California nursing homes in 1993 as a result of malnutrition, dehydration, and other serious conditions for which they did not receive acceptable care. Poor nutrition, dehydration, and improper care of incontinent and immobile residents can result in bedsores (pressure sores) or urinary tract infections, which, if not properly treated, can lead to more serious infection and death. The federal government, through the Health Care Financing Administration (HCFA), and the state of California, through its Department of Health Services (DHS), share oversight responsibilities for California nursing homes that participate in the Medicare and Medicaid programs. To assess compliance with federal standards, DHS relies primarily on a yearly standard survey conducted by nurses or other staff with medical or social service backgrounds who review the care and services provided by the homes. California has more than 1,400 nursing homes, with over 141,000 resident beds. The Medicare and Medicaid programs paid these homes approximately \$2 billion in 1997.

Concerned about the life-threatening potential of these conditions, you asked us to (1) examine, through a medical record review, whether these allegations had merit and whether serious care problems currently exist; (2) review the adequacy of federal and state efforts in monitoring nursing home care through annual surveys; and (3) assess the effectiveness of federal and state efforts to enforce sustained compliance with federal nursing home requirements.

To address the allegations pertaining to the acceptability of care in 1993, two registered nurses, one with a doctoral degree in gerontological nursing and the other with a master's degree in the same field, and both with clinical expertise in nursing home care and data abstraction, conducted a clinical review of the medical records for a sample of residents included in the allegations. Using clinical practice guidelines, published research, and professional judgment concerning acceptable nursing home care, the nurses determined whether residents received acceptable or unacceptable care. Their work was further reviewed by another registered nurse on our staff with experience working in nursing homes and judging

whether care met acceptable clinical standards. This second review focused specifically on a critical examination of all cases in which the first team of registered nurses identified residents as having had unacceptable care. Our registered nurse also discussed some of the cases with physicians and additional registered nurses specializing in geriatric care to further clarify whether care was acceptable or unacceptable. From this second review, we excluded all questionable cases from the final unacceptable care group. Because of our sampling method, the results of this analysis of medical records pertaining to deaths in 1993 cannot be generalized to the universe of all residents in California nursing homes operating then or now.

To assess the adequacy of federal and state efforts in monitoring nursing home care, we (1) reviewed federal and state data that showed the results of surveys, complaint investigations, and enforcement actions taken from 1995 to 1998; (2) accompanied state surveyors during their regularly scheduled annual survey of two nursing homes and, with the help of a second team of registered nurses experienced in assessing nursing home care, conducted a concurrent survey of care at these two homes; and (3) interviewed officials from nursing homes, DHS, HCFA, nursing home industry associations, and advocacy groups. Before releasing the draft for official comment, we consulted with a number of noted clinical experts,¹ who reviewed our findings and found the report well supported and balanced.

We conducted our work between October 1997 and July 1998 in accordance with generally accepted government auditing standards. (See app. I for a detailed description of our scope and methodology.) In addition to this report, we are currently conducting, for you and other requesters, a broader-based review that addresses nursing home enforcement nationwide. We expect to issue that report early in 1999.

¹ They included Sydney Katz, M.D., Professor Emeritus of Geriatric Medicine, Columbia University, who had led the Institute of Medicine study that influenced the Omnibus Budget Reconciliation Act of 1987 nursing home reforms; Mathy Mezey, Ed.D., R.N., FAAN, Independence Foundation Professor of Nursing Education, New York University, and Director of the Hartford Institute for Geriatric Nursing; John W. Rowe, M.D., President of Mount Sinai Medical Center and School of Medicine; and T. Franklin Williams, M.D., Professor of Medicine Emeritus and Department of Veterans Affairs Distinguished Physician, University of Rochester School of Medicine and Dentistry, and Director, National Institute on Aging, National Institutes of Health (1983 through 1991).

RESULTS IN BRIEF

----- Letter :1

Overall, despite the federal and state oversight infrastructure currently in place, certain California nursing homes have not been and currently are not sufficiently monitored to guarantee the safety and welfare of their residents. We reached this conclusion primarily by using data from federal surveys and state complaint investigations conducted by California's DHS on 1,370 California homes, supplemented with our more in-depth analysis of certain homes and certain residents' care. We also found that surveyors can miss problems that affect the safety and health of nursing home residents and that even when such problems are identified, enforcement actions do not ensure that they are corrected and do not recur.

With regard to allegations made about avoidable deaths in 1993, our expert nurses' review of the 62 resident cases sampled\2 found that residents in 34 cases received care that was unacceptable and that sometimes endangered their health and safety. Our team found such care problems as inadequate intervention by the nursing home to prevent dramatic, unplanned weight loss and failure to properly treat pressure sores that became infected and toxic. However, in the absence of autopsy information that establishes the cause of death, we cannot be conclusive about the extent to which this unacceptable care may have contributed directly to individual deaths.

Unacceptable care continues to be a problem in many homes. For example, our analysis of federal survey and state complaint investigations found that nearly 1 in 3, or 407, of 1,370 California nursing homes were cited by state surveyors for having serious or potentially life-threatening care problems.\3

Moreover, we believe that the extent of current serious care problems portrayed in these federal and state data is likely to be understated. We found that homes could generally predict when their annual on-site reviews would occur and, if inclined, could take steps to mask problems otherwise observable during normal operations. In addition, we found instances of irregularities in the homes' documentation of the care provided to their residents, such as missing pages of clinical notes needed to explain a resident's injury later identified through physician observation. These types of irregularities could shield from surveyor scrutiny such problems as inadequate staffing or avoidable injuries. Finally, in visiting homes selected by California DHS officials themselves, our team found multiple cases in which DHS surveyors did not identify certain serious care problems--including unaddressed dramatic weight loss and related nutritional problems. Surveyors missed these and other care problems, in part, because federal guidance on conducting surveys does not include sampling methods that can enhance the spotting of potential problems and help establish their prevalence.

Even when the state identifies serious deficiencies, HCFA's enforcement policies have not been effective in ensuring that the deficiencies are corrected and remain corrected. For example, California state surveyors had cited about 1 in 11 homes in our analysis--accounting for over 17,000 resident beds--for violations in both of their last two surveys that resulted in harm to residents. Nevertheless, HCFA generally took a lenient stance toward many of these homes. California's DHS, consistent with HCFA's guidance on imposing sanctions, grants all noncompliant homes--except for the few homes that qualify as posing the greatest danger to residents--a 30- to 45-day grace period. During this period, these homes may correct deficiencies without penalty, regardless of their past performance. In addition, a substantial number of California's homes that have been terminated and later reinstated have soon thereafter been cited again for serious deficiencies when reviewed in subsequent surveys. Recognizing its enforcement shortcomings, California's DHS launched a pilot program this month intended to target for increased vigilance certain of the state's nursing homes with the worst performance records.

Although our report focuses on nursing homes in California, the problems we identified are indicative of systemic survey and enforcement weaknesses. Our recommendations therefore target federal guidance in general so that improvements are available to any state experiencing problems with seriously noncompliant homes. Thus, through HCFA's leadership, federal and state oversight of nursing homes can be strengthened nationally and residents nationwide can enjoy increased protection.

\2 Our criteria for inclusion in the sample were that a case came from a home with at least 5 of the allegedly avoidable deaths and at least 5 such deaths per 100 beds; 72 nursing homes met these criteria. The 62 cases were drawn randomly and came from 15 of those nursing homes.

\3 The 1,370 homes represent 95 percent of Medicare- and Medicaid-certified homes in California in operation at some time between July 1, 1995, and February 26, 1998.

BACKGROUND

----- Letter :2

The Omnibus Budget Reconciliation Act of 1987 (OBRA 87) introduced major reforms in the federal regulation of nursing homes that responded to growing concerns about the quality of care that residents received. Among other things, these reforms revised care requirements that facilities must meet to participate in the Medicare or Medicaid programs, modified the survey process for certifying a home's compliance with federal standards, and introduced additional sanctions and decertification procedures for homes that fail to meet federal standards.

OVERSIGHT IS SHARED FEDERAL AND STATE RESPONSIBILITY

----- Letter :2.1

The federal responsibility for overseeing nursing facilities belongs to HCFA, an agency of the Department of Health and Human Services (HHS). Among other tasks, HCFA defines federal requirements for nursing home participation in Medicare and Medicaid and imposes sanctions against homes failing to meet these requirements. The law requires HCFA to contract with state agencies to survey nursing homes participating in Medicare and Medicaid. In California, DHS performs nursing home oversight, and its authority is specifically defined in state and federal laws and regulations. As part of this role, DHS (1) licenses nursing homes to do business in California; (2) certifies to the federal government, by conducting reviews of nursing homes, that the homes are eligible for Medicare and Medicaid payment; and (3) investigates complaints about care provided in the licensed homes.

To assess nursing home compliance with federal and state laws and regulations, DHS relies on two types of reviews--the standard survey and the complaint investigation. The standard survey, which must be conducted no less than once every 15 months at each home, entails a team of state surveyors spending several days on site conducting a broad review of care and services with regard to meeting the assessed needs of the residents.\4 The complaint investigation entails conducting a targeted review with regard to a specific complaint filed against a home. California state law mandates that a complaint must be investigated within 2 to 10 days, depending on the seriousness of the infraction being alleged. HCFA requires that any complaint involving immediate jeopardy to a resident's health or safety be investigated within 48 hours.

\4 The standard survey is used not only to meet HCFA's requirement to certify homes for Medicare and Medicaid participation but also to ensure that a home is continuing to meet its state licensing.

requirements.

SEPARATE FEDERAL AND STATE
ENFORCEMENT SYSTEMS

----- Letter :2.2

The state and HCFA each has its own enforcement system for classifying deficiencies that determines which remedies, sanctions, or other actions should be taken against a noncompliant home. During standard surveys, California's DHS typically cites deficiencies using HCFA's classification and sanctioning scheme; for complaint investigations, it generally uses the state's classification and penalty scheme, which allows the imposition of penalties and other actions under state enforcement criteria.

Table 1 shows HCFA's classification of deficiencies and their accompanying levels of severity and compliance status.

Table 1

HCFA's Deficiency Classification System

HCFA deficiency category	Level of severity	Compliance status of home cited for this deficiency
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Immediate jeopardy to resident health or safety	Most serious	Noncompliant
Actual harm that does not put resident in immediate jeopardy	Serious	Noncompliant
No actual harm, with potential for more than minimal harm	Less serious	Noncompliant
No actual harm, with potential for minimal harm	Minimal	Substantiall y compliant
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HCFA guidance also classifies deficiencies by their scope, or extent, as follows: (1) isolated, defined as affecting a limited number of residents; (2) pattern, defined as affecting more than a limited number of residents; and (3) widespread, defined as affecting all or almost all residents. HCFA guidance on citing a deficiency's scope as "widespread" states that "the universe" [of residents required for determining 'widespread'] is the entire facility," not just those who, by their condition, would have been affected by the deficiency cited. The example provided explains that if a facility was deficient in appropriately treating all of a facility's tube-fed residents--but the number of tube-fed residents was less than the facility's total number of residents--surveyors must cite the deficiency's scope as "pattern" and not widespread.

Whether a deficiency is judged by surveyors to be isolated, a pattern, or widespread has implications for enforcement. For example, under HCFA regulations, a home is to be cited for "substandard quality of care" when it has certain deficiencies exceeding a particular severity and scope level. Receiving a substandard rating is significant because, depending on a home's past performance, such a rating can prompt stronger enforcement actions than are typically taken under HCFA policy.

The deficiencies that can warrant a substandard rating involve federal requirements related to quality of care, quality of life, and resident behavior and facility practices. Any of these types of deficiencies involving immediate jeopardy to resident health and safety results in a substandard rating. In addition, these types of deficiencies lead to a substandard rating if they are of the following severity and scope combinations: a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm that is not immediate jeopardy, with no actual harm.

SERIOUS CARE PROBLEMS FOUND IN
MANY NURSING HOMES REVIEWED

----- Letter :3

The work of our expert nurses indicates that some of California's nursing home residents who died in 1993 received unacceptable care that, in certain cases, endangered their health and safety. We also found evidence that serious care problems exist today in California nursing homes. Data from standard and complaint surveys indicate that nearly a third of California's nursing homes experience serious care problems.

REVIEW OF 1993 MEDICAL
RECORDS UNCOVERED SERIOUS
CARE PROBLEMS

----- Letter :3.1

We examined medical records of residents who died in 1993 from such causes as malnutrition, dehydration, pressure sores, and urinary tract infections with sepsis (the presence of bacteria and toxins in the blood or tissue). Their deaths were alleged to have been caused by unacceptable nursing home care. The 3,113 cases of alleged unacceptable care were distributed across nearly three-fourths of California's nursing homes in 1993. However, to avoid selecting isolated instances of such deaths, our cases were drawn from about 5 percent of California's homes that had at least five of the allegedly avoidable deaths. Our review suggests that 34 residents--more than half of the 62 cases reviewed--received unacceptable care.\5 Our expert nurses concluded that, in some of these cases, unacceptable care endangered residents' health and safety. Care problems included dramatic, unplanned weight loss, failure to properly treat pressure sores, and failure to manage pain. The examples in figure 1 illustrate the nature of the care problems we identified.

Figure 1: Examples of
Quality-of-Care Problems Found
in Review of 1993 Medical
Records

(See figure in printed
edition.)

In other cases we reviewed from 1993, the care documented in the medical record was acceptable. For example, when nursing home staff recognized that a resident was having difficulty swallowing food, they changed her diet to pureed food and placed the resident in a restorative feeding program, where she received additional help in eating. Although the resident later refused all food and liquid and eventually died of dehydration, our expert reviewers concluded that the nursing home staff provided acceptable care during the resident's 4-month stay in the home. The cause of death listed on her death

certificate might raise questions about the care she received, but only medical record review could determine whether the care was acceptable.

\\5 Care was considered unacceptable based on the clinical judgment of our nurse reviewers--using practice guidelines to help them reach their judgment-- and supplemented with additional review. The unacceptable care they identified led to outcomes that caused serious harm to some residents. Care given in 1993 was not analyzed as to whether the homes would have been considered compliant using HCFA's 1995 enforcement requirements.

STATE'S QUALITY REVIEWS SHOW
SUBSTANTIAL CARE PROBLEMS
OCCURRING TODAY

----- Letter :3.2

DHS surveyors identified a substantial number of homes with serious care problems through their annual standard surveys of nursing homes and through ad hoc complaint investigations. Through examining the most recent two surveys from homes that had at least two standard surveys conducted between July 1995 and February 1998, and that may have had complaint investigations in 1996 or 1997, we found that surveyors cited 407 homes--nearly a third of the 1,370 homes included in our analysis--for serious violations classified under the federal deficiency categories, the state's categories, or both. These homes were cited for violations that caused death, seriously jeopardized residents' health and safety, or were considered by state surveyors to have constituted substandard care.

Figure 2 shows the distribution of the nursing homes included in our analysis by the seriousness of the federal and state violations cited.

Figure 2: Distribution of
1,370 California Nursing Homes
by Seriousness of Federal and
State Violations Cited, 1995-98

(See figure in printed
edition.)

Note: Violations can be federal deficiencies cited in either of a home's two most recent surveys or state deficiencies cited for 1996 or 1997.

\\a Federal and state violations in this category include (1) improper care leading to death and (2) life-threatening harm or other serious injury--federal violations classified as immediate and serious jeopardy and state violations cited as class AA or A. Federal violations also include a specified set of 49 deficiencies of severity and scope that constitute substandard care. State violations additionally include intentional falsification of medical records or material omission in medical records.

\\b Federal and state violations in this category include harm to a resident that regulators judged to be less than life-threatening--federal violations classified as causing residents actual harm that do not put a resident in immediate jeopardy and are not classified as substandard care. State violations included in this category are those cited as class B, which have a direct or immediate relationship to the health, safety, or security of a

resident.

\c Federal violations in this category include deficiencies that have not caused actual harm but could cause more than minimal harm to residents if not corrected. California has no directly equivalent state citation for this category.

\d Homes in this category either were cited for no violations or for federal violations that did not cause harm to residents but could result in minimal harm if not corrected. California has no directly equivalent state citation for this category.

The four wedges in figure 2 correspond to federal deficiency categories shown in table 1 and include comparable-level deficiencies cited using the state's separate classification scheme, as follows:

- "Caused death or serious harm" represents any federal deficiency that surveyors classified as constituting immediate jeopardy or substandard care and California deficiencies of improper care leading to death, imminent danger or probability of death, intentional falsification of medical records, or material omission in medical records.
- "Caused less serious harm" represents federal violations constituting actual harm but not immediate jeopardy or substandard care and California violations that have a direct or immediate relationship to the health, safety, or security of a resident.
- "More than minimal deficiencies" represents federal violations that could cause more than minimal harm to residents if not corrected.
- "Minimal or no deficiencies" represents either no violations or federal violations that could have resulted in minimal harm to residents if not corrected.

Figure 3 shows the distribution of types of deficiencies in the category called "caused death or serious harm" and gives examples of each type. The category "improper care leading to death" does not include all residents who died in homes cited for violations related to residents' care, because the category "life-threatening harm" can also include such violations and associated deaths.

Figure 3: Examples of
Deficiencies DHS Cited Between
1995 and 1998 That Correspond
to the "Caused Death or Serious
Harm" Category in Figure 2

(See figure in printed
edition.)

\a State violations cited as class AA.

\b Federal violations classified as "immediate and serious jeopardy" and state violations cited as class A. This category includes some violations causing harm that were associated with a resident's death.

\c Federal violations are classified as "substandard quality of care" if (1) the deficiencies are in one of three requirement categories--quality of care, quality of life, and resident behavior and facility practices and (2) their prevalence is widespread and has a potential for harming residents, or they have harmed more than a limited number of residents or put the health and safety of one or

more residents in immediate jeopardy. Substandard quality-of-care violations that put residents in immediate jeopardy are included in "life-threatening harm" in this figure.

\d State violations classified as "intentional falsification of medical records" or "material omission in medical records." Three other homes were cited for falsification of or key omissions from medical records, but because they were also cited for other serious care violations, they were included in the "other serious improper care" group.

We also found examples of poor care that were ranked by state surveyors as causing less serious harm under the federal and state classification systems. For example, the cases described in figure 4 were not classified in the group of "most serious" violations.

Figure 4: Examples of
Deficiencies DHS Cited Between
1995 and 1998 That Correspond
to the "Caused Less Serious
Harm" Category in Figure 2

(See figure in printed
edition.)

Deficiencies classified as "potential for more than minimal harm"--corresponding to the "more than minimal deficiencies" category in figure 2--can also include problems more serious than their classification implies, as figure 5 shows.

Figure 5: Examples of
Deficiencies DHS Cited Between
1995 and 1998 That Correspond
to the "More Than Minimal
Deficiencies" Category in
Figure 2

(See figure in printed
edition.)

Homes with deficiencies classified as having "potential for minimal harm"--corresponding to the "minimal or no deficiencies" category in figure 2--are considered by HCFA to be in substantial compliance, as shown in table 1. However, figure 6 shows examples of deficiencies that California surveyors classified in this category in which the harm could be considered by some to be greater than minimal.

Figure 6: Examples of
Deficiencies DHS Cited Between
1995 and 1998 That Correspond
to the "Minimal or No
Deficiencies" Category in
Figure 2

(See figure in printed
edition.)

PREDICTABILITY OF SURVEYS,
QUESTIONABLE RECORDS, AND
SURVEY LIMITATIONS HINDER
EFFORTS TO IDENTIFY CARE
PROBLEMS

----- Letter :4

The deficiencies that state surveyors identified and documented very likely capture part but not the full extent of care problems in California's homes, for several reasons. Some homes can mask problems because they are able to predict the timing of annual reviews or because medical records sometimes contain inaccurate information that overstates the care provided, given the resident's observed condition. In addition, state surveyors can miss identifying deficiencies because of limitations on the methods used in the annual review--methods established in HCFA guidance on conducting surveys--to identify potential areas of unacceptable care.

SURVEYS' PREDICTABLE TIMING
LIKELY CONCEALS ADDITIONAL
CARE PROBLEMS

----- Letter :4.1

The extent of care problems is likely to be masked because of the predictability of homes' standard surveys. The law requires that a standard survey be unannounced, that it begin no later than 15 months after the last day of the previous standard survey, and that the statewide average interval between standard surveys not exceed 12 months. Because many California homes were reviewed in the same month--sometimes almost the same week--year after year, homes could often predict the timing of their next survey and, if inclined, prepare to cover up problems that may normally exist at other times. For example, a home that may routinely operate with too few staff could temporarily augment its staff during the period of the survey in order to mask an otherwise serious deficiency in staffing levels. Advocates and residents' family members told us they believe that such staffing adjustments are common, given their own observations in homes they visited.

At two homes we visited, we saw that the homes' officials had made advance preparations--such as making a room ready for survey officials--indicating that they knew the approximate date and time of their upcoming oversight review. When we discussed these observations with California DHS officials, they acknowledged that a review of survey scheduling showed that the timing of some homes' surveys had not varied by more than a week or so for several cycles. DHS officials have since instructed district office managers to schedule surveys in a way that reduces their predictability.

The issue of the predictable timing of surveys is long-standing. In the mid-1980s, the Institute of Medicine recommended adjusting the timing of surveys to make them less predictable and maximize the element of surprise. It suggested that standard surveys be conducted between 9 and 15 months after the previous standard survey.⁶ In OBRA 87, the Congress established a civil monetary penalty to be levied against an individual who notifies a nursing home about the time or date of an impending survey. In 1995, HCFA issued guidance to states to keep the timing of the standard survey unpredictable by ensuring that all surveys are unannounced. However, the guidance is silent on varying the survey cycle as a way to reduce the predictability of these reviews.

Since the guidance was issued, two studies have found that regular timing of surveys is still a problem. The National State Auditors Association found that in nine states it studied, the timing of inspections in some states was around the same date every year, which allowed nursing homes to predict when their survey would occur.⁷ Similarly, nursing home advocates in 41 states and the District of Columbia polled by HCFA noted that the predictability of surveys was a continuing problem.⁸ One state's advocate noted that a home's care, food, and environment change dramatically as the time of the

home's standard survey nears.

 \6 The Institute of Medicine, Improving the Quality of Care in Nursing Homes (Washington, D.C.: Institute of Medicine, 1986), pp. 32-33.

\7 National State Auditors Association, National State Auditors Association Joint Performance Audit: Long-Term Care (Baton Rouge, La.: Performance Audit Division, Louisiana Office of the Legislative Auditor, 1998).

\8 HCFA conducted a telephone survey of state nursing home ombudsmen to determine whether the ombudsmen had observed changes in nursing homes since the 1995 implementation of the revised survey and enforcement processes. Ombudsmen are members of the local community who are trained and certified to assist in resolving problems raised by nursing home residents, their families, and others.

QUESTIONABLE RECORDS SUGGEST
 THAT SOME AMOUNT OF POOR
 CARE ESCAPES DETECTION IN
 RECORD REVIEWS

----- Letter :4.2

Another reason quality problems in nursing homes escape detection is the questionable accuracy of some resident medical records. When conducting on-site reviews, surveyors screen residents' medical records for indicators of improper care; if information in the records is misleading or omitted, surveyors may fail to identify care deficiencies.

Studies of nursing home quality cite questionable accuracy of resident medical records as a problem. For example, one study found that nursing home staff often incorrectly record the amount of food consumed by residents, thus calling into question the information maintained on the adequacy of residents' nutrition.\9 Another study examined records on the use of restraints compared with actual restraint use. In this study, although nursing home records showed that staff had removed residents' restraints every 2 hours as required, researcher observation revealed that, in fact, 56 percent of the residents had been continuously restrained for 3 hours or longer.\10

In the course of reviewing the 1993 medical records, we also found inaccuracies and otherwise misleading information. The examples in figure 7, abstracted from the 1993 California records we reviewed, illustrate the implausibility or suspicious omissions of information contained in some residents' records. We found discrepancies in about 29 percent of the 1993 California records we reviewed.

Figure 7: Examples of
 Questionable Medical Records in
 1993

(See figure in printed
 edition.)

\a According to medical experts, a 5-percent weight loss in 1 month is significant.

\9 Jeanie Kayser-Jones and others, "Reliability of Percentage Figures Used to Record the Dietary Intake of Nursing Home Residents," Nursing Home Medicine, Vol. 5, No. 3 (Mar. 1997), pp. 69-76.

\10 John F. Schnelle, Joseph G. Ouslander, and Patrice A. Cruise, "Policy Without Technology: A Barrier to Improving Nursing Home Care," The Gerontologist, Vol. 37, No. 4 (1997), pp. 527-32.

RECENT SERIOUS CARE PROBLEMS
MISSED IN COMPREHENSIVE
STANDARD SURVEYS

----- Letter :4.3

Through medical record reviews as well as direct observation at two homes, we found that the standard surveys at these facilities failed to identify a number of serious care problems.\11 In our visits to two facilities during their annual surveys, we arranged for our team of registered nurses to accompany the state surveyors and conduct concurrent surveys designed specifically to identify quality-of-care problems.\12 Our survey methodology differed from the methodology specified by HCFA guidance and used by state surveyors in three major ways: (1) we selected a stratified, random sample of a much larger number of cases to review, including vulnerable populations such as new admissions and those at risk for pressure sores; (2) we collected uniform information on those cases using a structured protocol for observations, chart review, and staff interviews; and (3) we compared the results from those cases at each facility with data collected under the same sampling method at more than 60 other nursing homes nationwide, and then targeted our case review in areas where we identified a facilitywide pattern that could denote poor care. Using this methodology, we were able to spot cases in which the homes had not intervened appropriately for residents experiencing weight loss, dehydration, pressure sores, and incontinence--cases the state surveyors either missed or identified as affecting fewer residents.

At the two homes where our nurses conducted their quality-of-care surveys, the findings of our team and those of DHS surveyors were similar in some respects and different in others. For example, state surveyors cited one of the homes (home A) for a high medication error rate that was not found by our surveyors. However, problems state surveyors missed included unaddressed nutrition and weight loss, failure to prevent pressure sores, and poor management of resident incontinence--cases in which the homes had not intervened appropriately. (See fig. 8 for examples of such problems in home A.)

Figure 8: Examples of Problems
Our Surveyors Found That DHS
Surveyors Missed in On-Site
Review, Home A

(See figure in printed
edition.)

\a People who receive tube feeding generally should not lose weight, according to medical experts, because the amount of caloric intake can be monitored to maintain a stable weight.

DHS surveyors classified home A's violations as posing potential for more than minimal harm to residents and, according to standard practice for deficiencies classified at this level, required the home to produce a corrective action plan. In contrast, we determined, on the basis of the problems shown in figure 8, that this home had a pattern of poor care and classified this home's care for unaddressed

nutrition and weight-loss problems, pressure sore problems, and incontinence problems as conditions demonstrating actual harm.

At home B, we noted that the state surveyors had found a considerable number of problems, including some that were similar to those we found. For example, both teams found pressure sore treatment and infection control deficiencies. The state surveyors also found problems we did not identify, including the home's failure to provide oral hygiene to residents and to appropriately administer an intravenous medication to one resident. However, the state surveyors overlooked quality-of-care problems that we detected and considered serious. Among those missed were problems in the category of "failure to provide appropriate personal and preventive care." (See fig. 9.)

Figure 9: Examples of Problems
Our Surveyors Found That DHS
Surveyors Missed in On-Site
Review, Home B

(See figure in printed
edition.)

DHS surveyors classified home B's violations as resulting in actual harm but determined that the harm was isolated rather than systemic.¹³ By defining the extent of the deficiencies as isolated, DHS followed its standard practice--for a deficiency cited at this level--of requiring the home to submit a corrective action plan. In contrast, by using a larger sample, we were able to establish a frequency of cases demonstrating a pattern of actual harm.

 \11 At a third home, we gathered information on survey procedures but did not conduct a concurrent review of residents' records or facility care.

\12 The scope of our team's survey was limited to quality-of-care issues, whereas the state surveyors had a broader scope of review that included requirements in 14 other areas, such as administration and dietary services.

\13 The nursing home challenged the state's classification of the identified deficiency and succeeded in having the finding reduced from actual harm to potential for more than minimal harm.

HCFA'S SURVEY METHODOLOGY LIMITS IDENTIFICATION OF CARE PROBLEMS

----- Letter :4.4

Several factors account for the different assessments of care between the two survey teams. First, in reviewing medical records to identify areas with potential for poor care, our surveyors took random samples of cases from several types of residents, including the most vulnerable residents. Second, the number of cases our surveyors drew was large enough to estimate how common the problems were in the homes. Third, the information our surveyors collected from medical record reviews, staff interviews, and data analyses was entered into a structured format and compared with similar information from more than 60 other homes nationwide. This allowed our surveyors to pinpoint areas where care seemed problematic and review those cases thoroughly.

HCFA policy establishes the procedures, or protocol, that state surveyors must follow in conducting a home's standard survey. Selecting cases for review is an activity that occurs early in the standard survey of a home to identify potential instances of poor care. At the beginning of a standard survey, the nursing home administrator must supply surveyors with documents that specify, among other things, a census of residents by medical condition, such as numbers of individuals with pressure sores, indwelling catheters, and physical restraints. The state surveyors use this information to select the majority of cases for particular scrutiny during the survey. They may add to the list of cases after observing residents and talking with nursing home staff.

HCFA's protocol for selecting cases does not call for taking a random sample of sufficient size, however, and relies primarily on the use of professional expertise and judgment, based on numerous criteria that HCFA offers as guidance. While professional judgment is an essential component in identifying poor care, the nonrandom nature of the sample and its insufficient size precludes the state surveyor from easily determining the prevalence of the problems identified.

The protocol our surveyors used for sampling allowed them to cast a wider net. Specifically, they took random samples of three groups of residents to target cases in which poor care would be most likely to surface. The three groups sampled were classified as "new admissions," "long stays" (residents more than 105 days into their stay), and "sentinel events" (residents whose medical conditions put them at the greatest risk for poor outcomes). By stratifying the sample and taking a random selection of a sufficient number of each group, our surveyors could project the results of the samples to all residents in the home, thus assessing the potential prevalence of their initial review findings.¹⁴ For each resident in the sample, the survey team collected information from observations, chart reviews, and staff interviews assessing 75 elements reflecting quality-of-care outcomes. Our surveyors then profiled these findings--that is, they compared the data from the sampled cases with data collected under the same sampling method at more than 60 nursing homes in other states.

Analyzing data collected from the cases sampled, our survey team compared a home's rate of poor outcomes against the rates determined for the homes in other states.¹⁵ For example, they found that, at the two homes discussed, the rate of pressure sores was 27 percent and 21 percent of each home's total residents, whereas the comparison homes' average rate was roughly 8 percent. Being able to compare rates of medical conditions in a nursing home, such as the percentage of residents with pressure sores, allows the surveyor to determine whether the home is an outlier in comparison with other homes. Our surveyors then used this information to review residents' care regarding specific conditions to determine whether the poor outcome rates were due to unacceptable care or were justifiable because of other factors.

HCFA has just begun to implement a requirement for all nursing homes participating in Medicare and Medicaid to transmit electronically certain data they maintain on residents' health and functional status. Having this information in computerized form could provide surveyors better access to residents' outcome data, thus potentially enhancing surveyors' ability to select cases for review more systematically and quickly. Access to information in this form could also facilitate assessing a home's performance with regard to residents' outcomes against an established average or norm. These benefits will depend, however, on ensuring that these data are valid and reliable reflections of residents' status and care.

\14 The methodology used by our surveyors could add to the time necessary for state surveyors to complete a survey. This survey methodology examined quality-of-care outcomes only, whereas state surveyors, following federal guidance, must review 14 additional areas, such as social services, resident assessment, and transfer and discharge activities.

\15 To perform this profiling analysis, our surveyors used customized software and a laptop computer.

HCFA'S ENFORCEMENT POLICIES
INEFFECTIVE AT BRINGING HOMES
CITED REPEATEDLY FOR SERIOUS
PROBLEMS INTO COMPLIANCE

----- Letter :5

Once surveyors find deficiencies through nursing home surveys, their next step is to have the homes correct their deficiencies and return to compliance with federal requirements. Despite HCFA's goal to have nursing homes sustain compliance with federal requirements over time, our work in California showed that 1 in 11 California homes--serving thousands of residents--were cited twice in a row for "actual harm" violations. Relatively few disciplinary actions were taken against such homes because of HCFA's forgiving stance on enforcement. HCFA's termination policy is likewise generous--allowing California homes terminated from the program for serious problems to be easily reinstated--even though they often have serious care violations in subsequent surveys. Recognizing these and other weaknesses in the current process, California's DHS has begun a "focused enforcement" effort and has implemented procedures to strengthen its use of available nursing home enforcement authority for facilities with the poorest past performance records.

SUSTAINED COMPLIANCE GOAL
NOT MET FOR CERTAIN HOMES
SERVING THOUSANDS OF
RESIDENTS

----- Letter :5.1

OBRA 87 requires the HHS Secretary to ensure that the enforcement of federal care requirements for nursing homes is adequate to protect the health, safety, welfare, and rights of residents. In the background to its final regulations, HCFA stated that its system of requirements implementing OBRA 87 reforms "was built on the assumption that all requirements must be met and enforced" and that its enforcement actions will encourage "sustained compliance." In addition, HCFA noted that "our goal is to promote facility compliance by ensuring that all deficient providers are appropriately sanctioned." \16 However, our data suggest that current enforcement efforts in California are not reaching the stated goal to ensure that all requirements are met and deficient providers are appropriately sanctioned, and also may not fulfill the OBRA 87 promise to protect the health, safety, welfare, and rights of residents. National data indicate this problem is not limited to California.

A significant number of homes in our analysis had repeated violations in categories that HCFA classifies as "serious" or "most serious." Specifically, 122 homes--representing over 17,000 resident beds--were cited in both of their last two surveys for conditions causing actual harm or conditions that put residents in immediate jeopardy or caused death. \17 The repeated deficiencies included, among others, problems

with infection control, pressure sore treatment, and bladder continence care.\18 Preliminary analysis of national data indicates that repeating serious deficiencies is more common nationally than in California. One in nine nursing homes in the United States--representing more than 232,000 resident beds--were cited in both of their last two surveys for conditions that caused actual harm or put residents in immediate jeopardy or caused death.

Relatively few disciplinary actions have been taken against homes cited for repeated harm violations. Before OBRA 87, the only sanction available to HCFA and the states to impose against such noncompliant homes, short of termination, was to deny federal payments for new admissions. Because this sanction afforded HCFA and the states an opportunity to defer the decision to terminate, it was considered an "intermediate" sanction. OBRA 87 provided for additional intermediate sanctions, such as denial of payment for all admissions, civil monetary penalties, and on-site oversight by the state ("state monitoring").\19

Nevertheless, between July 1995 and May 1998, nearly three-quarters of those 122 homes--cited in at least 2 consecutive years for serious deficiencies--had no federal intermediate sanctions that actually took effect.

 \16 59 FR 56116-56117.

\17 Sixty-six percent of these homes are classified in figure 2 in the category "caused death or serious harm," and 34 percent are classified as "caused less serious harm."

\18 A much greater number--1,083 homes--were also out of compliance with federal nursing home requirements in both of their last two surveys; however, they were not cited in two consecutive surveys for deficiencies classified in the actual harm or immediate jeopardy categories.

\19 Other sanctions include third-party management of a home for a temporary period ("temporary management"); requirement for a home to follow a corrective action plan developed by HCFA, the survey agency, or a temporary manager--with HCFA or survey agency approval--rather than by the facility itself ("directed plan of correction"); and mandatory training of a home's staff on a particular issue ("directed in-service training").

HCFA'S FORGIVING ENFORCEMENT
 STANCE HELPS EXPLAIN HOW
 SOME HOMES CAN REPEATEDLY
 HARM RESIDENTS WITHOUT
 FACING SANCTIONS

----- Letter :5.2

Our review of federal actions taken against California's noncompliant homes indicates that HCFA's policies, as implemented by California's DHS, have not led to sustained compliance, either for some homes immediately referred for sanctioning\20 or for others given a grace period to correct their deficiencies. In addition, HCFA has reinstated California homes terminated for serious deficiencies that became problem homes soon after reinstatement.

 \20 OBRA 87 and HCFA's implementing regulations refer to certain

actions as "remedies" that HCFA has also called intermediate sanctions, such as civil monetary penalties, denial of payment for new or for all admissions, and temporary management. In this report, we use the term "sanction."

OVERSIGHT OF HOMES
IMMEDIATELY REFERRED FOR
SANCTIONING NOT ADEQUATE
TO ENSURE SUSTAINED
COMPLIANCE

----- Letter :5.2.1

HCFA guidance instructs state agencies to immediately refer for federal sanctioning homes that meet HCFA criteria for posing the greatest danger to residents. The immediate referral contrasts with the practice of first granting homes a grace period to correct cited deficiencies. To qualify for immediate referral, homes must be cited for violations in the immediate jeopardy category or be rated as a "poor performer." HCFA's definition of poor performer itself is circumscribed such that the definition applies to relatively few homes. A home must have been cited on its current standard survey for substandard quality of care and have been cited in one of its two previous standard surveys for substandard quality of care or immediate jeopardy violations. Homes cited for cases of actual harm to residents--if assessed at the isolated level--do not satisfy HCFA's criteria for the substandard quality-of-care classification. Since July 1995, when the federal enforcement scheme established in OBRA 87 took effect, about 25 California homes have been designated as poor performers and 59 homes have been cited for immediate jeopardy deficiencies. HCFA guidance permits the state to broaden the definition of poor performer, but California has chosen not to do so.\21

Even homes immediately referred for sanctioning do not necessarily receive sanctions that take effect. Among California homes HCFA considers to have the most serious deficiencies that immediately jeopardize resident health and safety, only about half had any sanctions that actually took effect. If homes come into substantial compliance before sanctioning is scheduled to take effect, HCFA rescinds the sanction.

In principle, sanctions imposed against a home remain in effect until the home corrects the deficiencies cited and until state surveyors find, after an on-site review (called a "revisit") that the home has resumed substantial compliance status. HCFA's guidance on revisits allows states to forgo an on-site visit and accept a home's report of resumed compliance status if the home's deficiencies are not more serious than the "potential for harm" range and do not constitute substandard care. HCFA officials told us this policy was put into place because of resource constraints. In California, however, this policy has been applied even to some of the immediate referral homes that continue to have deficiencies that put them out of substantial compliance upon revisit. Thus, our review of certain enforcement cases showed that HCFA failed to ensure that homes with a record of posing the greatest danger to residents had, in fact, resumed substantial compliance.

For example, in the case of one home immediately referred for sanctioning, DHS surveyors made a few on-site reviews, but HCFA twice accepted the home's self-reported statement of compliance without requesting DHS to revisit and independently verify that the home had fully corrected its deficiencies.\22

Specifically, in an October 1996 survey, DHS cited the home for

immediate jeopardy and actual harm violations, including improper pressure sore treatment, medication errors, insufficient nursing staff, and an inadequate infection control program. By early November 1996, however, surveyors had found in an on-site review that the problems had abated but had not fully ceased. A week later, the home reported itself to HCFA as resuming substantial compliance. HCFA accepted this report without further on-site review.

About 6 months later (May 1997), in the home's next standard survey, DHS found violations that warranted designating the home a poor performer. On a revisit to check compliance in July 1997, surveyors found new but less serious deficiencies. In August 1997, however, when the home reported itself in compliance, HCFA accepted the report without further verification. Between October 1996 and August 1997, HCFA imposed several sanctions but lifted them each time it accepted the home's unverified report of resumed compliance.\23

\21 For example, California could include in the poor performer definition a home's record of violations cited in the course of complaint investigations. Unlike standard surveys, complaint investigations are generally unexpected and provide surveyors a unique opportunity to gauge care issues in a home's everyday environment. Because these investigations can uncover serious quality-of-care problems, regulators would get a more complete picture of a home's compliance history if the results of complaint investigations were included in the "poor performer" determination.

\22 A home reports itself to HCFA as being in compliance by sending HCFA a letter called a "credible allegation of compliance."

\23 In the October 1996 survey, HCFA imposed a civil monetary penalty that went into effect October 3 and was stopped from further accrual on November 8 when HCFA determined federal requirements had been met, based on the survey that had found lower-level deficiencies. In the May 1997 standard survey, HCFA imposed a civil monetary penalty to take effect in May 1997 and a denial of payment for new admissions sanction to take effect in July 1997, both of which HCFA stopped in August 1997 when the home reported that it was in compliance.

WIDELY GRANTED GRACE
PERIODS LEAD TO AMNESTY
FOR SERIOUS VIOLATORS

----- Letter :5.2.2

According to HCFA guidance, noncompliant homes that are not classified in the immediate jeopardy or poor performer categories do not meet HCFA's criteria for immediate referral for sanctioning, even though residents may have suffered actual harm. Following this guidance, California's DHS first notifies these homes of the sanctions it will recommend imposing unless the home resumes compliance. DHS revisits the homes where residents have suffered actual harm or worse to ensure that compliance has been achieved. In practice, on the basis of HCFA's guidance, the state will forward notification of the recommended sanctions to HCFA only if the home fails to correct the deficiencies cited within a 30- to 45-day grace period allowed by HCFA. Although California's DHS regulators have the option of referring the home immediately for disciplinary action, the accepted practice under HCFA's guidance is to first allow the home to return to compliance status within the specified grace period.

HCFA policy permits granting a grace period to this group of

noncompliant homes, regardless of their past performance. Between July 1995 and May 1998, California's DHS gave about 98 percent of noncompliant homes\24 a grace period to correct deficiencies. For nearly the same period (July 1995 to April 1998), the rate of noncompliant homes receiving a grace period nationwide was 99 percent, indicating that the practice of granting a grace period to nearly all noncompliant homes is common across all states.

Moreover, data we analyzed on actions taken against California homes cited repeatedly for harming residents suggest that DHS does not take into account a home's compliance history when determining whether to impose intermediate sanctions. Of the 122 homes in our analysis cited repeatedly for harming residents, 73 percent were not federally sanctioned. In the case of such homes--cited in consecutive surveys for actual harm or immediate jeopardy violations--granting a grace period with no further disciplinary action appears to be a highly questionable practice. Table 2 illustrates a home with the same violations cited 4 years in a row--thus not sustaining compliance from one standard survey to the next--and still receiving a grace period to correct its deficiencies after each survey.

Table 2

Example of Home Awarded Grace Periods
Year After Year, Despite Repeated
Noncompliance

Date	Selected deficiencies cited	Action tak
August 1994 standard survey	Pressure sores: A resident was admitted following the surgical repair of a broken hip in an acute-care institution. While in the nursing home, she developed a pressure sore at the incision site on her hip. It progressed to a stage IV (most severe) pressure sore. At the time of the survey, she was being treated for the probability of bone infection (osteomyelitis) of that hip caused by the pressure sore. Later, another lesion developed on the opposite extremity. The home did not provide care to prevent either the development or progression of the sore. This second pressure sore also progressed to a bone infection.	Home submi corrective action pla is subsequ found in substantia compliance
September 1995 standard survey	Pressure sores: In the case of several residents, the home failed to assess skin conditions as potential pressure sores, thus failing to implement appropriate pressure sore treatment. Personnel also failed to properly treat sores once they were identified. In one case, for example, the home did not properly treat a resident during a 6-month period for a pressure sore that developed from clear skin into an open area on the resident's knee and quickly worsened to a larger, more severe sore.	Home submi corrective action pla is subsequ found in substantia compliance
October 1996 standard survey	Pressure sores: Nurses were found to have neglected treating pressure sores for 16 percent of residents sampled. The nurses did not follow the plans established for treating the sores and did not clean the sores in a clean, safe way.	Home submi corrective action pla is subsequ found in substantia compliance

December
1997
standard
survey

Pressure sores:

An incontinent resident at risk for pressure sores was found lying in urine-soaked linens nine separate times during a 4-day survey.

Another resident was admitted to the home with clear skin, except for a sore on his left heel. The sore worsened over a 3-month period, but the home did not intervene. Ultimately, because of the sore's severity, the physician recommended that the leg be amputated below the knee.

Twenty percent of sampled residents without pressure sores when admitted did not receive appropriate preventive care. An additional 10 percent of residents sampled were not given proper treatment of existing sores or care to prevent new ones.

Home submi
corrective
action pla
is subsequ
found in
substantia
compliance

 \a This enforcement action was taken before the implementation of OBRA 87 enforcement provisions.

 \24 Table 1 shows HCFA's deficiency classification system and associated compliance status.

HCFA REINSTATES MOST TERMINATED HOMES

----- Letter :5.2.3

Although HCFA has the authority to terminate homes from participation in Medicare and Medicaid if they fail to resume compliance, termination rarely occurs and is not as final as the term implies. In the recent past, California's terminated homes have rarely closed for good. Of the 16 homes terminated in the 1995 to 1998 time period, 14 have been reinstated. Eleven have been reinstated under the same ownership they had before termination. Of the 14 reinstated homes, at least six have been cited since their reinstatement with new deficiencies that harmed residents, such as failure to prevent avoidable accidents, failure to prevent avoidable weight loss, and improper treatment of pressure sores.

A home that reapplies for participation is required to have two consecutive on-site reviews--called reasonable assurance surveys--within 6 months to determine whether it is in substantial compliance with federal regulations before its eligibility to bill federal programs can be reinstated. However, HCFA has not always ensured that homes are in substantial compliance before reinstatement. For example, one home terminated on April 15, 1997, had two reasonable assurance surveys on April 25 and May 28, 1997. Although the nursing home was not in substantial compliance at the time of the second survey, HCFA considered the deficiencies minor enough to reinstate the home on June 5, 1997. The consequence of termination--stopping reimbursement for the home's Medicare and Medicaid beneficiaries--was in effect for no longer than 3 weeks.\25

About 3 months after reinstatement, however, the home was cited for harming residents. DHS surveyors investigating a complaint found immediate jeopardy violations as a result of a dangerously low number of nursing home staff. In addition, surveyors cited the facility for providing substandard care. Residents who could not move independently, some with pressure sores, were left sitting in urine and feces for long periods of time; some residents were not getting

proper care for urinary tract infections; and surveyors cited the home's infection control program as inadequate.

\\25 Under Medicare and Medicaid rules, terminated nursing homes may be paid for care of residents in the home from the date of termination up to 30 days after the termination takes effect.

CALIFORNIA DHS PILOTS
ALTERNATIVE ENFORCEMENT
PROCEDURES TARGETING A SMALL
GROUP OF MOST SERIOUSLY
DEFICIENT HOMES

----- Letter :5.3

By 1997, California DHS officials recognized that the state, in combination with HCFA's regional office, had not dealt effectively with persistently and seriously noncompliant nursing homes using the OBRA 87 enforcement process. The process discouraged immediate application of enforcement actions. It allowed nursing homes to come back into compliance for a short period of time, escaping enforcement action altogether. In many instances, though, homes did not sustain compliance for a significant period of time. Therefore, in July 1998 and with HCFA's agreement, DHS began a "focused enforcement" process that combines state and federal authority and action, targeting providers with the worst compliance records for special attention.

As a start, DHS has identified about 34 homes with the worst compliance histories--generally two in each of its districts. Officials intend to conduct standard surveys of these homes about every 6 months rather than every 9 to 15 months. In addition, DHS intends to conduct more complete on-site reviews of facilities for all complaints received about these homes. DHS and HCFA told us that they do not intend to accept such homes' self-reports of compliance without a revisit. DHS officials told us that the agency is developing procedures--consistent with HCFA regulations implementing OBRA 87 reforms--to ensure that, where appropriate, the state will immediately recommend and HCFA will impose civil monetary penalties and other strong sanctions to bring such homes into compliance and keep them compliant. For focused enforcement homes unable to sustain compliance, state officials plan to revoke their state licenses and recommend termination from the Medicare and Medicaid programs. In addition, DHS plans to screen the compliance history of facilities by owner--both in California and nationally--before granting new licenses to operate nursing homes in the state. State officials told us that they will require all facilities with the same owner to be in substantial compliance before any new licenses are granted.

CONCLUSIONS

----- Letter :6

The responsibility to protect nursing home residents, among the most vulnerable members of our society, rests with nursing homes and with HCFA and the states. In a number of cases, this responsibility has not been met in California. We and state surveyors found cases in which residents who needed help were not provided basic care--not helped to eat or drink; not kept dry and clean; not repositioned to prevent pressure sores; not monitored for the development of urinary tract infections; and not given pain medication when needed. When such basic care is not provided, residents may suffer unnecessarily.

As serious as the identified care problems are, weaknesses in federal

and state oversight of nursing homes raise the possibility that many care problems escape the scrutiny of surveyors. Homes can prepare for surveyors' annual visits because of the visits' predictable timing. Homes can also adjust resident records to improve the overall impression of the home's care. In addition, DHS surveyors may overlook significant findings because the federal survey protocol they follow does not rely on an adequate sample for detecting potential problems and their prevalence. Together, these factors can mask significant care problems from the view of federal and state regulators.

Furthermore, HCFA needs to reconsider its enforcement approach toward homes with serious, recurring violations. Federal policies allowing a grace period to correct deficiencies and to accept a home's report of compliance without an on-site review can be useful policies, given resource constraints, when applied to homes with less serious problems. However, even with resource constraints, HCFA and DHS need to ensure that their enforcement efforts are directed to homes with serious and recurring violations and that policies developed for homes with less serious problems are not applied to them.

Under current policies and practices, noncompliant homes that DHS identifies as having harmed or put residents in immediate danger have little incentive to sustain compliance, once achieved, because they may face no consequences for their next episode of noncompliance. Our findings regarding homes that repeatedly harmed residents or were reinstated after termination suggest that the goal of sustained compliance has not been met. Failure to bring such homes into compliance limits the ability of federal and state regulators to protect the welfare and safety of residents.

RECOMMENDATIONS

----- Letter :7

In order to better protect the health, safety, welfare, and rights of nursing home residents and ensure that nursing homes sustain compliance with federal requirements, we recommend that the HCFA Administrator revise federal guidance and ensure state agency compliance through taking the following actions:

- Stagger or otherwise vary the scheduling of standard surveys to effectively reduce the predictability of surveyors' visits; the variation could include segmenting the standard survey into more than one review throughout the 12- to 15-month period, which would provide more opportunities for surveyors to observe problematic homes and initiate broader reviews when warranted.
- Revise federal survey procedures to instruct surveyors to take stratified random samples of resident cases and review sufficient numbers and types of resident cases so that surveyors can better detect problems and assess their prevalence.
- Eliminate the grace period for homes cited for repeated serious violations and impose sanctions promptly, as permitted under existing regulations.
- Require that for problem homes with recurring serious violations, state surveyors substantiate, by means of an on-site review, every report to HCFA of a home's resumed compliance status.

AGENCY COMMENTS AND OUR
RESPONSE

Some reviewers questioned whether the scope of our clinical review of 1993 records and concurrent review of nursing homes was sufficient to permit drawing conclusions about the current condition of all California nursing homes. These aspects of our methodology--while important--were not the primary basis for reaching our conclusions. The most comprehensive and compelling evidence we analyzed was recent standard survey reports of California's own surveyors, the statewide database DHS maintains on complaint investigations, and the nationwide database HCFA maintains on nursing home deficiencies. In

response to these comments, we modified the report to better clarify our methodology and the primary basis for our findings.

----- Letter :8.1

As agreed with your offices, unless you publicly announce its contents earlier, we plan no further distribution of this report until July 28, 1998. At that time, we will make copies of this report available to interested parties upon request.

Please contact me or Kathryn Allen, Associate Director, at (202) 512-7114 if you or your staff have any further questions. This report was prepared by Jack Brennan, Scott Berger, Mary Ann Curran, C. Robert DeRoy, Gloria Eldridge, and Hannah Fein, under the direction of Sheila Avruch.

William J. Scanlon
Director, Health Financing
and Systems Issues

OBJECTIVES, SCOPE, AND METHODOLOGY

===== Appendix I

Concerned about the life-threatening potential of the recent allegations, you asked us to determine whether the allegations had any merit and whether the monitoring of California's nursing homes has been adequate to protect residents. More specifically, we assessed (1) whether, as alleged, residents who died in 1993 from certain causes had received unacceptable care that could have endangered their health and safety, and whether serious care problems currently exist; (2) the adequacy of federal and state efforts in monitoring nursing home care through annual surveys; and (3) the effectiveness of federal and state efforts to enforce sustained compliance with federal nursing home requirements.

We reviewed the medical records of a sample of the 3,113 residents alleged to have died avoidable deaths in 1993 in 971 California nursing homes from malnutrition, dehydration, urinary tract infection (UTI), bowel obstruction, or bedsores (pressure sores). We met with those making the allegations, and from them we obtained copies of the death certificates of the 3,113 residents. To select our sample, we eliminated residents with UTI who did not also suffer from septicemia (the presence of bacteria and toxins in the blood), because if these conditions are not present, UTI is generally not lethal. We assumed that if care was a problem in a home, more than one resident would have been affected. We therefore excluded death certificates for residents of homes with (1) fewer than five such deaths and (2) for such deaths, a deaths-to-total-beds ratio of less than 5 percent. That left a universe of 546 residents at 72 homes. In addition, we eliminated residents who died in counties having few nursing homes. After these exclusions, our universe became 446 residents at 59 homes, from which we selected a preliminary sample of 75 residents from 15 homes. Fourteen of these homes were freestanding and one was a hospital-based nursing home. Because we selected from residents of homes with five or more such deaths in certain counties, our results cannot be generalized to the universe of all residents in California nursing homes who died of the same causes in 1993.

To review the medical records, we used two registered nurses with advanced degrees in gerontological nursing and with expertise in clinical nursing home care and data abstraction. To guide them, another registered nurse on our staff developed a detailed structured data collection instrument.\26 The nurses' work was reviewed by the

registered nurse on our staff, who has experience working in nursing homes and judging whether care met acceptable clinical standards. This second review focused on a critical examination of all cases where the first team of registered nurses identified residents as having unacceptable care, in order to exclude any cases that might be questionable rather than unacceptable. The registered nurse on our staff also discussed some of the cases with physicians and additional registered nurses specializing in geriatric care to further clarify whether care was acceptable. We excluded all questionable cases from the unacceptable care group. Because of the time needed to thoroughly review each resident's complete clinical history (some were more than 600 pages), the nurses reviewed 62 of the 75 records initially selected from 1993.

To determine the extent of deficiencies identified by state surveyors in California nursing homes since July 1995, and to identify enforcement actions taken in response to the deficiencies, we used two databases. The first, HCFA's On-Line Survey, Certification, and Reporting (OSCAR) System, contains information about violations of federal requirements that a home has received in its last four surveys. The second, the Automated Certification and Licensing Administrative Information Management System (ACLAIMS) database, is maintained by California's DHS and contains information on each home's violations of state requirements. In addition, we used data that HCFA's San Francisco regional office maintains separately from OSCAR on federal sanctions imposed.

In OSCAR, we identified 1,445 California homes that had survey data after July 1, 1995--the date the new OBRA 87 scope and severity system went into effect. If a nursing home at a particular address had more than one provider number, we included in our analysis only one of the provider numbers to represent that home. Of the 1,445 California homes, 1,370 of those homes (95 percent) had at least two surveys entered into the OSCAR database since July 1995. Information in the OSCAR database is constantly being updated. We downloaded OSCAR data on February 26, 1998, to get a fixed database for our analysis of 1,370 homes. We also continued to work with OSCAR on-line as necessary, for example, to download survey reports on particular homes. The nursing homes we analyzed included Medicare and Medicaid dually certified facilities, Medicare-only facilities, Medicaid-only facilities, and both freestanding and hospital-based facilities. To develop information shown in figures 2 and 3, we combined information from both the OSCAR and ACLAIMS databases.

We did not conduct a thorough assessment of the validity or reliability of either OSCAR or ACLAIMS. We did determine, however, that OSCAR excludes data that could be useful in obtaining a complete picture of a nursing home's history of deficiencies. For example, serious violations of state requirements discovered during complaint investigations are not routinely shown as federal deficiencies in OSCAR. Other information, such as the seriousness and extent of identified deficiencies, were missing from OSCAR in some cases. We found instances of missing information in 282 of the 1,370 homes in our analysis. The effect of these omissions from the database, we believe, is an understatement of documented deficiencies in OSCAR.

To assess the effectiveness of the survey process, we accompanied California state surveyors on annual standard surveys conducted at two homes. To do this, we arranged for a team of registered nurses to accompany the DHS surveyors and conduct concurrent surveys using a protocol developed under a HCFA research contract designed specifically to identify quality-of-care problems. These nurses work with Andrew M. Kramer, M.D., of the University of Colorado's Center on Aging Research Section of the Health Sciences Center, who developed the survey protocol for HCFA. Before conducting the

concurrent surveys at these homes, we accompanied a state survey team to a third home to gather information on survey procedures.

To better understand survey deficiencies, complaints, and enforcement, we reviewed selected records. We determined the types of problems being identified by surveyors by obtaining and analyzing annual standard surveys for 18 homes we visited. We also obtained and analyzed information about the number and type of complaints investigated by two district offices. To better understand enforcement efforts, we reviewed selected enforcement files and enforcement data kept by HCFA.

We also interviewed responsible officials from HCFA headquarters in Baltimore and HCFA's San Francisco regional office. We met with officials from California DHS in Sacramento and two district offices; the California Association of Health Facilities; the American Health Care Association; the American Association of Homes and Services for the Aging; the California Association of Homes and Services for the Aging; the California Advocates for Nursing Home Reform; California's Office of Ombudsman; nursing home administrators and directors of nursing; geriatricians and registered nurses with expertise in nursing home issues; and families of nursing home residents.

(See figure in printed edition.)Appendix II

\\26 The protocol was developed primarily from two documents--American Health Care Association, The Long Term Care Survey (no date); and Andrew M. Kramer and others, Pilot Test of a Staged Quality of Care Survey Using Quality Indicator Profiles (Sept. 1995). The protocol was then refined through consultation with experts and a GAO methodologist and pretested using an initial chart review.

COMMENTS FROM THE HEALTH CARE
FINANCING ADMINISTRATION

===== Appendix I

(See figure in printed edition.)

(See figure in printed edition.)

(See figure in printed edition.)

(See figure in printed edition.)

(See figure in printed edition.)

(See figure in printed edition.)

(See figure in printed edition.)Appendix III
COMMENTS FROM CALIFORNIA'S
DEPARTMENT OF HEALTH SERVICES

===== Appendix I

(See figure in printed edition.)

(See figure in printed edition.)

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Fraud and Abuse: Providers Target Medicare Patients in Nursing Facilities
(Letter Report, 01/24/96, GAO/HEHS-96-18).

Pursuant to a congressional request, GAO reviewed allegations of fraud and abuse related to services and supplies provided to nursing facility patients, focusing on: (1) the nature and extent of such fraud and abuse exist; (2) why nursing facility patients are an attractive target for miscreants; and (3) options for reducing fraudulent billing practices.

GAO found that: (1) fraudulent and abusive billing of Medicare is widespread and frequent and a wide variety of providers have been involved in Medicare fraud or abusive billing related to nursing facility patients' care; (2) most fraud and abuse involves billing Medicare for unnecessary or undelivered services and supplies or misrepresenting services to obtain reimbursement; (3) Medicare patients in nursing facilities are attractive fraud targets because of the high volume and concentration of Medicare beneficiaries in nursing facilities, easier access to patients' medical records, billing without confirmation, the lack of sufficient and timely warning flags in Medicare's automated claim processing systems, and inadequate recovery of unwarranted payments; (4) to change its reimbursement method to incorporate the nursing facilities' monitoring of the provision of services and supplies Medicare will need long-term commitment, structural changes, unified billing, and capped payments; and (5) short-term steps to reduce fraud and abusive billing include instituting federal penalties for unauthorized disclosure of patients' medical records and incorporating various early warning controls into Medicare's claim processing systems.

----- Indexing Terms -----

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 TITLE: Fraud and Abuse: Providers Target Medicare Patients in
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 DATE: 01/24/96
 SUBJECT: Health care programs
 Fraud
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 Claims processing
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 Long-term care
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 Medical expense claims
 Billing procedures
 IDENTIFIER: Medicare Program

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Cover

===== COVER

Report to the Ranking Minority Member, Committee on Commerce, House
of Representatives

January 1996

FRAUD AND ABUSE - PROVIDERS TARGET
MEDICARE PATIENTS IN NURSING
FACILITIES

GAO/HEHS-96-18

Targeting of Nursing Facility Patients

(101291)

Abbreviations

===== ABBREV

EKG - electrocardiogram
HCFA - Health Care Financing Administration
HHS - Department of Health and Human Services
HMO - health maintenance organization
OIG - Office of the Inspector General

Letter

===== LETTER

B-255730

January 24, 1996

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

Dear Mr. Dingell:

At recent congressional hearings on efforts to trim billions of dollars from the rapidly growing Medicare program, we testified on the program's vulnerabilities to waste, fraud, and abuse.\1 Among the major weaknesses is the Health Care Financing Administration's (HCFA) inadequate array of controls--both for detecting billing abuses and for ensuring the legitimacy of providers billing the Medicare program.\2

One of your concerns focused on the numerous allegations of fraud and abuse related to services provided to Medicare patients in nursing

facilities.\3

In 1995, physicians, medical equipment companies, laboratories, and other providers were reimbursed an estimated \$5.5 billion for the services and supplies they furnished Medicare patients in nursing facilities. Because some portion of this amount is likely to have been paid unnecessarily, you asked us to review (1) the nature and extent of fraud and abuse related to services and supplies provided to nursing facility patients, (2) the conditions that make the provision of services and supplies to nursing facility patients an attractive opportunity for wrongdoers, and (3) options for removing such opportunity.

For this review, we interviewed officials at HCFA, Medicare claims processors, HHS Office of Inspector General (OIG), and several national organizations representing the nursing home industry and providers of services and supplies. We also analyzed documents for ongoing and recently completed investigations by Medicare claims processors and OIG, and interviewed investigators working on those cases to identify factors leading to fraudulent and abusive billing situations. Our work was done between April 1994 and August 1995 in accordance with generally accepted government auditing standards. Further details of our scope and methodology are provided in appendix I.

\1 See Related GAO Products at the end of this report.

\2 Within the U.S. Department of Health and Human Services (HHS), HCFA establishes regulations and policy guidance for the Medicare program.

\3 In this report, the term "nursing facility" is used to describe a nursing home that could provide services ranging from skilled care for patients with complex medical or rehabilitative needs to custodial care for those patients needing assistance with activities of daily living.

RESULTS IN BRIEF

----- Letter :1

Although most providers are honest and bill appropriately, a wide array of provider types--including durable medical equipment suppliers, laboratories, physicians, optometrists, and psychiatrists--have been involved in the fraudulent or abusive billing of Medicare for services and supplies furnished to nursing facility patients. The wrongdoing has generally focused on billing Medicare for unnecessary or undelivered services, or misrepresenting a service to obtain reimbursement. The investigations we reviewed probed activities in over 40 states, with many providers operating in multiple states. Although not quantifiable, the evidence suggests that such fraud and abusive billing activities are frequent and widespread.

Several features make Medicare beneficiaries in nursing homes an attractive target for fraudulent and abusive activity. First, because a nursing facility locates individual Medicare beneficiaries under one roof, unscrupulous billers of services can operate their schemes in volume. Second, in some instances, nursing facilities make patient records available to outside providers who are not responsible for the direct care of the patient, contrary to federal regulations which prohibit such inappropriate access. In such cases, nursing facilities--however inadvertently--enable exploitative

providers to obtain the information on Medicare beneficiaries that they need to bill Medicare.

Third, under HCFA's provisions for reimbursement, providers can bill Medicare directly, without the nursing facility or attending physician affirming whether the items were necessary or provided as claimed. Nor is the scrutiny at the claims processor level adequate. Medicare's automated systems do not accumulate data that would flag timely indications of improbably high charges or levels of services. As a result, Medicare claims processors miss opportunities to avoid paying out large sums unnecessarily and to track schemes exploiting groups of vulnerable beneficiaries. Finally, even when Medicare detects abusive billings and seeks recovery of unwarranted payments, it often receives little repayment from the wrongdoers who either go out of business or deplete their resources so that they lack the resources to repay the funds.

Medicare needs to change the way it reimburses for services and supplies provided to beneficiaries residing in nursing facilities. Because these facilities have a primary role in planning their residents' care, they are in the best position to monitor the provision of services and supplies. Although options exist for such involvement of nursing facilities, all require structural--and therefore long-term--changes. In the meantime, certain incremental changes would make the nursing facility environment less hospitable to fraudulent or abusive billing activities. These changes include instituting penalties at the federal level for the unauthorized disclosure of patients' medical records and programming various early warning controls in Medicare's claims processing systems to better detect fraud and abusive billings before claims are paid.

BACKGROUND

----- Letter :2

As the nation's largest health care payer, Medicare provides health insurance coverage to over 36 million elderly and disabled Americans. Medicare part A covers inpatient care in a hospital or skilled nursing facility and home health or hospice care. The care in skilled nursing facilities that part A covers--for which Medicare paid an estimated \$6.6 billion in 1995--is limited to relatively short stays for patients who need daily skilled care following hospitalization. Most elderly people in nursing facilities do not qualify for part A coverage.

Medicare part B covers physician services, outpatient hospital services, durable medical equipment, and various other health services. Although the vast majority of Medicare patients in nursing facilities do not require skilled nursing care, they are entitled to the full range of services and supplies covered by the Medicare part B program when part A does not pay for the nursing facility services themselves.⁴ This care is usually billed directly to Medicare by the providers who serve these patients. In 1995, Medicare paid an estimated \$5.5 billion for services and supplies furnished to patients in nursing facilities.

HCFA contracts with insurers, such as Blue Cross and Blue Shield plans, Aetna, and The Travelers Insurance Company, to process and pay claims submitted by providers. These contractors--referred to as carriers under Medicare part B--are responsible for the monitoring and analysis of claims both before and after payment to ensure that Medicare dollars are used to pay only reasonable and necessary claims. Carriers' automated claims processing systems include computerized controls, or screens, that screen claims for diagnosis coding errors, billing abuses, and incorrect or incomplete

documentation. Some controls deny or adjust claims payments automatically without human intervention. Others flag claims for further review by carrier personnel if the claims do not conform to payment criteria or are submitted by a provider under carrier scrutiny.

Nursing facility patients--many of whom are cognitively impaired--rely on the facility to manage their care needs. Under the nursing home reform provisions established by the Omnibus Budget Reconciliation Act of 1987, nursing facilities have a major role in designing plans of care for each of their patients. The act imposed requirements that nursing facilities provide those services and activities necessary to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Upon a patient's admission to a facility, a registered nurse must conduct or coordinate a comprehensive assessment of medical, nursing, mental, and psychosocial needs. The facility must then develop a comprehensive plan of care for the patient that includes measurable objectives and timetables to meet the patient's needs identified in the comprehensive assessment. Each assessment must be reviewed at least every 3 months; any revisions must be reflected in the corresponding plan of care.

\\4 Stays in nursing facilities are primarily paid by the individual or Medicaid.

INSTANCES OF WRONGFUL BILLING
SUGGEST WIDESPREAD ACTIVITY

----- Letter :3

Fraudulent and abusive practices by some providers who furnish services and supplies to nursing facility patients entail billing Medicare for unnecessary or undelivered services and supplies or misrepresenting a service or supply item to obtain Medicare reimbursement as the following examples show:

A company billed Medicare for heart monitoring services provided to nursing facility patients. The diagnoses entered on the Medicare claims forms by the laboratory were false and did not reflect the patients' condition at the time services were ordered and rendered. Medicare overpaid this company an estimated \$4.3 million.\\5

An optometrist filed Medicare claims for services either not medically necessary or not provided to nursing facility patients from 1991 through 1993. Medicare paid this practitioner over \$190,000 for these services.

A supplier billed Medicare for ostomy, enteral, and surgical dressing supplies that it had not delivered and forged the attending physicians' signatures on the certificates of medical necessity using samples of signed orders found in patients' files. This case involved about 4,000 fraudulent claims totaling about \$1.5 million.

These fraudulent and abusive activities involve a wide array of provider types, including ambulance service companies, dentists, medical equipment suppliers, general practitioners, internists, laboratories, optometrists, podiatrists, psychiatrists, and psychologists. The actual extent of the problem cannot be quantified, but the evidence suggests that it is widespread.\\6 Our review of ongoing and completed investigations by Medicare carriers

and HHS OIG included cases encompassing at least 41 states, the District of Columbia, and Puerto Rico. Thirty of the providers in these cases operated in multiple states as these examples illustrate:

A supplier currently under investigation for allegedly billing Medicare for surgical dressing kits and components that were not provided or medically necessary operates in at least 20 states.

Another supplier with offices in at least seven states billed Medicare for incontinence supplies that were inflated in price, not provided, or not medically necessary.\7

Another company under investigation for inappropriately billing Medicare for heart monitoring services operates in at least 11 states.

Because data on fraud and abuse have not been accumulated based on place of service, investigators cannot quantify the extent of Medicare fraud and abuse involving the provision of services and supplies to nursing facility patients. Medicare carriers and OIG officials believe, however, that fraud involving services provided in nursing facilities is significant. In 1994, the Senate Special Committee on Aging reported a considerable number of cases involving the targeting of nursing facility patients by industries that supply products and services directly to them.\8 Also in 1994, OIG reported on a completed investigation in which Medicare had paid over \$7.4 million to a billing company (representing 70 nursing facilities in 7 states) that had billed for surgical dressings supplied to nursing facility patients who had had no surgery. And in February 1995 testimony before the House Committee on Ways and Means, Subcommittee on Health, the Inspector General reported that about half of the \$230 million Medicare approved in 1993 nationally for incontinence supplies was questionable. The Inspector General noted that "the potential for great profit provides an incentive for fraudulent marketing and billing schemes which target the entire nursing home population of Medicare beneficiaries." \9

\5 An additional \$655,000 approved for payment was withheld by the Medicare claims processing contractor once the contractor had identified the problem.

\6 See app. II for examples of closed fraud investigations.

\7 The controller of the parent company recently pled guilty to submitting more than \$4.4 million of false and fraudulent claims to one Medicare carrier and similarly submitting millions of dollars of bogus claims to other carriers.

\8 Gaming the Health Care System, Billions of Dollars Lost to Fraud & Abuse Each Year, Investigative Staff Report of Senator William S. Cohen, Ranking Minority Member, Senate Special Committee on Aging (July 7, 1994).

\9 Statement by Michael Mangano, Principal Deputy Inspector General, Office of Inspector General, HHS, for Oversight Hearings Before the House of Representatives, Committee on Ways and Means, Subcommittee on Health (Feb. 6, 1995).

SERVICES PROVIDED AT NURSING
FACILITIES SUSCEPTIBLE TO FRAUD
AND ABUSE

----- Letter :4

The nursing facility setting can be an inviting target of opportunity for the unscrupulous provider of part B services and supplies. First, a vulnerable population grouped together at a single location offers the opportunity for volume billing. Second, HCFA's provisions for reimbursing providers of these part B services and supplies furnish little early warning of egregious overutilization or rapid increases in billings.

NURSING FACILITIES DO NOT
ALWAYS MONITOR SERVICES OR
SUPPLIES FURNISHED BY
OUTSIDE PROVIDERS

----- Letter :4.1

Federal requirements call for nursing facilities to perform numerous tasks to monitor and meet patient care needs, but there are no similar requirements to monitor claims submitted directly to Medicare for services or supplies provided to nursing facility patients. HCFA's reimbursement system for part B services and supplies allows providers to bill Medicare without adequate confirmation that the care or items were necessary or were delivered as claimed. As a result, the program is highly vulnerable to exploitation. Also, despite the emphasis on patient care, the cases we reviewed demonstrate that nursing facilities often do not control provider access to records closely enough and opportunists are permitted to exploit Medicare.

Nursing facilities generally do not have the in-house capability to provide all the services and supplies that patients need. Accordingly, outside providers market their services and supplies to nursing facilities to meet the needs of the facilities' patients. OIG has reported that provider representatives typically enter nursing facilities and offer to handle the entire transaction--from reviewing medical records to identify those patients their products or services can help, to billing Medicare--with no involvement by nursing facility staff.¹⁰ Some facilities allow providers or their representatives to review patient medical records despite federal regulations that prohibit such unauthorized review.¹¹ These representatives gain access to records not because they have any responsibility for the direct care of those patients, but because they want to market their services or supplies. We found that unscrupulous providers can obtain all the information necessary to order, bill, and be reimbursed by Medicare for services and supplies that are in many instances not necessary or even provided. The following are two examples of this practice:

A supplier obtained a list of Medicare patients at three nursing facilities together with their Medicare numbers from another supplier who had access to specific Medicare billing information for certain patients at these facilities. The first supplier billed Medicare for large quantities of supplies that were never provided to these patients and then paid the second supplier half of the approximately \$814,000 it received in reimbursement.

A group optometrical practice performed routine eye examinations on nursing home patients, a service not reimbursable by Medicare. The optometrist was always preceded by a sales person who targeted the nursing facility's director of nursing or its social worker and claimed the group was offering eye examinations at no cost to the facility or the patient. The nursing facility gave the sales person access to patients' records, and this person then obtained the information necessary to file claims. Nursing staff would obtain physicians' orders

for the "free" examinations, and an optometrist would later arrive to conduct the examinations. The billings to Medicare, however, were for services other than eye examinations--services that were never furnished or were unnecessary.

The OIG and HHS attorneys with whom we spoke agreed that granting providers of services and supplies unauthorized access to medical records contributes to fraud and billing abuse.\12 They stated that except in specific cases in which a resident's safety is jeopardized as a result, HHS lacks clear authority to impose monetary or other penalties on nursing facilities solely for providing such access.

\10 See Marketing of Orthotic Body Jackets (OEI-04-92-01081, Mar. 1994) and Marketing of Incontinence Supplies (OEI-03-94-00770, Dec. 1994).

\11 Based on 42 CFR 483.75(l)(4), all information contained in the patients' records must be kept confidential except when release is required by (1) transfer to another health care institution; (2) law; (3) third party payment contract; or (4) the resident.

\12 OIG refers to this practice in an August 1995 Special Fraud Alert entitled, "Fraud and Abuse in the Provision of Medical Supplies to Nursing Facilities."

LITTLE CHANCE OF TIMELY
DETECTION OF EXCESSIVE
MEDICARE REIMBURSEMENTS

----- Letter :4.2

Although carriers employ a number of effective automated controls to prevent or remedy some inappropriate payments, such as suspending claims for further review that do not meet certain conditions for payment, our work shows that outlandish charges or very large reimbursements routinely escape the controls and typically go unquestioned. The carriers we reviewed had not put any "triggers" in place that would halt payments when cumulative claims exceed reasonable thresholds.

Our analysis showed that as a result, Medicare has reimbursed providers, who were subsequently found guilty of fraud or billing abuses, large sums of money over a short period without the carrier becoming suspicious. The following examples highlight the problem:

A supplier submitted claims to a Medicare carrier for surgical dressings furnished to nursing facility patients. In the fourth quarter of 1992, the carrier paid the supplier \$211,900 for surgical dressing claims. For the same quarter a year later, the contractor paid this supplier more than \$6 million without becoming suspicious despite a 2,800-percent increase in the amount paid.

A carrier's payments for a supplier's body jackets claims averaged about \$2,300 per quarter for five consecutive quarters, then jumped to \$32,000, \$95,000, \$235,000, and \$889,000 over the next four quarters, with no questions raised by the carrier.\13

In other instances, we found that providers subsequently investigated for wrongdoing billed and were paid for quantities of services or supplies that could not possibly have been furnished or necessary as these examples illustrate:

A carrier reimbursed a clinical psychology group practice for individual psychotherapy visits lasting 45 to 50 minutes when the top three billing psychologists in the group were allegedly seeing from 17 to 42 nursing facility patients per day. On many days the leading biller of this group would have had to work more than 24 uninterrupted hours to provide the services he claimed.

A carrier paid a podiatrist \$143,580 for performing surgical procedures on at least 4,400 nursing facility patients during a 6-month period. For these services to be legitimate, the podiatrist would have had to serve on average at least 34 patients per day, 5 days per week.

The Medicare carriers in these two cases did not become suspicious until they received complaints from family members, beneficiaries, or competing providers. In other cases, the carriers initiated their investigations because of their analysis of paid claims (a practice referred to as postpayment medical review), which focuses on those providers that appear to be billing more than their peers for specific procedures. One carrier, for instance, reimbursed a laboratory \$2.7 million in 1991 for heart monitoring services allegedly provided to nursing facility patients and \$8.2 million in 1992. The carrier was first alerted in January 1993 through its postpayment review efforts when it noted that this laboratory's claims for monitoring services exceeded the norm for its peers.

In all these cases, the large increases in reimbursements over a short period or the improbable cumulative services claimed for a single day should have alerted carriers to the possibility that something unusual was happening and prompted an earlier review. For example, people do not usually work 20-hour days, and billings by a provider for a single procedure do not typically jump 13-fold from one quarter to the next or progressively double every quarter.

\13 A body jacket is a custom-fitted spinal brace made of a rigid plastic material that conforms to the body and provides a high degree of immobility.

LIMITED RECOVERY OF LOSSES

----- Letter :4.3

Although Medicare carrier postpayment reviews do lead to fraud and billing abuse investigations, from the perspective of curtailing fraudulent or abusive billing activities, we found that these reviews often happen too late. In all the cases cited previously, the carriers did investigate the providers, but by the time the investigations began, Medicare had already made millions of dollars in unwarranted payments. The risk to the Medicare program, as evidenced by the fraud cases we reviewed, is that relatively little of the money inappropriately paid out is recovered as the following examples show:\14

The owners of a company that had received over \$4.3 million from Medicare based on fraudulent claims for heart monitoring argued before the court that \$250,000 was the most they could repay. In the settlement agreement, they agreed to reimburse Medicare \$250,000, plus interest, and be excluded from the Medicare program for 5 years.

The optometrist mentioned previously who billed for services never rendered and for undocumented consultations agreed, in a civil

settlement, to refund \$30,000 to Medicare over a 35-month period and to be excluded from the program for 3 years. Although Medicare had reimbursed this provider over \$450,000 on the basis of false or misleading claims, the case was settled for less because the provider had no assets from which the overpayments could be recovered.

Several companies under investigation since early 1993 for the submission of false claims for heart monitoring services have billed Medicare large sums over a 6- to 9-month period and then have gone out of business when Medicare began making billing inquiries. For example, within a month of Medicare's contacting one company for medical records, the company--which had already been paid at least \$1.4 million--closed its operations making it unlikely that Medicare can recover inappropriate payments.

\\14 See also our testimony on this subject, Medicare: Modern Management Strategies Needed to Curb Program Exploitation (GAO/T-HEHS-95-183, June 15, 1995).

OPTIONS FOR REIMBURSING PART B
CLAIMS FOR SERVICES PROVIDED TO
NURSING FACILITY PATIENTS

----- Letter :5

Our analysis showed that a major contributing factor to fraudulent and abusive billings for services and supplies provided nursing facility patients is that no one is ensuring that what is billed for is necessary or actually provided. Because nursing facilities already have a significant role in planning and providing patient care, they are the likely entity to scrutinize providers' reimbursement claims for services administered to the facilities' patients.

Several options for making nursing facilities accountable for costs incurred on behalf of their patients were suggested during our discussions with federal officials and such nursing facility industry representatives as the American Health Care Association. Each option would require a basic change in the way Medicare reimburses part B services and supplies provided to nursing facility patients:

Unified billing by the nursing facility: Under this approach, the nursing facility would bill Medicare for all services it is authorized to furnish to patients, whether payment is sought from part A or B. This would be the case whether the facility provided the care itself or contracted for the services or supplies to be provided by someone else. Outside providers would be prohibited from billing Medicare directly and would, in effect, have to have agreements with nursing homes. Absent an agreement, the nursing facility could not bill Medicare because it would not be financially liable or medically responsible for the care. By contrast, under the current system, outside providers can bill Medicare directly, without scrutiny by anyone where the care is delivered. Unified billing by the nursing facility would make it easier for Medicare to identify all the services furnished to residents, which in turn would make it easier to control payments for those services.

Capping payments: An alternative to paying on a fee-for-service basis as Medicare now does is to pay a fixed amount per beneficiary. This approach mirrors the payment method Medicare uses to reimburse most health maintenance organizations (HMO)

serving Medicare beneficiaries.\15 As with HMOs, Medicare would pay the nursing facility a fixed amount per month for all part B services and supplies provided to each resident beneficiary.\16 A variant, one that would apply only to skilled nursing facilities, would mirror the way Medicare pays hospitals for inpatient care. As with hospitals, Medicare would pay nursing facilities a predetermined fixed amount per patient based on the type of case or diagnosis-related group into which the patient is classified. Both variants of the capped payment approach would, by definition, limit Medicare outlays for these services, eliminating providers' incentive to provide too many services. By the same token, the incentive for nursing facilities to profit from accepting fixed payments while providing fewer services than necessary would need to be addressed. A further difficulty in these approaches is in establishing reasonable rates given the wide range of services provided individual nursing facility patients.

 \15 HMOs were designed to offer health services less expensively and to constrain the provision of extensive services, primarily through a reimbursement method known as capitation. Under capitation Medicare pays HMOs a fixed amount per month for each beneficiary. This method typically places HMOs at risk for health costs, thereby giving them a financial incentive to control the use of services and avoid unnecessary care. HMOs may use their own staff of physicians and other providers to deliver care or may contract with individual providers or medical groups to deliver services.

\16 The current method for reimbursing risk contract HMOs is not without its problems. See Medicare Managed Care: Program Growth Highlights Need to Fix HMO Payment Problems (GAO/T-HEHS-95-174, May 24, 1995).

CONCLUSIONS

----- Letter :6

Under Medicare neither the nursing facility nor the physician ensure that the services and supplies outside providers claim to have furnished to beneficiaries in nursing facilities are in fact necessary and actually provided. As a result, services provided to Medicare beneficiaries in nursing facilities offer a target of opportunity for the fraudulent schemes and billing abuses of the dishonest provider. To address the root cause of this accountability issue, Medicare needs to change the way it reimburses for services and supplies furnished patients in nursing facilities. Options range from those that can be implemented in the short term, such as allowing only nursing facilities to bill for all services and supplies provided to their patients, to the more difficult long-term solutions, such as capitation or prospective payment systems. All these options address the accountability issue, but more study is needed to assess the comparable costs and benefits of these options.

Certain immediate actions would help stem losses. First, carriers could establish computerized payment controls that, before payment, would detect and automatically suspend for further review claims that exceeded established thresholds for charges and utilization. The thresholds need not be based on statistical averages, but they should be based on an assumption about what is reasonable activity for specific procedures, provider types, beneficiaries, and places of service. Such controls could provide timely warnings and trigger investigations of potentially fraudulent and abusive billings before large sums were paid out. Second, nursing facilities should be held

accountable for the unauthorized disclosure of patient medical records. Giving providers or their representatives inappropriate access to patient medical records was a major contributing cause to the fraud and abuse cases we reviewed. Although such disclosure is contrary to program regulations, HCFA or HHS generally cannot levy penalties, monetary or otherwise, against a nursing facility for that unauthorized disclosure.

RECOMMENDATION TO THE CONGRESS

----- Letter :7

To curtail the practice of giving providers unauthorized access to beneficiary medical records, the Congress should authorize HHS OIG to establish monetary penalties that could be assessed against nursing facilities that disclose information from patients' medical records not in accord with existing federal regulation.

RECOMMENDATIONS TO THE
SECRETARY OF HHS

----- Letter :8

We recommend that the Secretary of HHS direct the Administrator of HCFA to

- establish, for procedure billing codes by provider or beneficiary, thresholds for unreasonable cumulative levels or rates of increase in services and charges, and to require Medicare carriers to implement automated screens that would suspend for further review claims exceeding those thresholds; and

- undertake demonstration projects designed to assess the relative costs and benefits of alternative ways to reimburse nursing facilities for part B services and supplies; these alternatives should include such options as unified billing by the nursing facility and some form of capped payment.

AGENCY COMMENTS

----- Letter :9

We provided HHS an opportunity to comment on our draft report, but it did not do so in time for comments to be included in the final report. We did discuss the report's contents with HCFA officials who generally agreed with our findings.

----- Letter :9.1

As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 15 days from the date of this letter. At that time, we will send copies of this report to the Secretary of HHS, the Administrator of HCFA, interested congressional committees, officials who assisted our investigation, and other interested parties. We will also make copies available to others upon request.

Please call me at (202) 512-7119 or Donald B. Hunter or Roland A. Poirier, Jr. at (617) 565-7500 if you have any questions.

Sincerely yours,

Edwin P. Stropko
Associate Director

Health Financing Issues

SCOPE AND METHODOLOGY

===== Appendix I

To develop the information in this report, we interviewed officials at HCFA's central office and the HHS Office of the Inspector General in Baltimore; three Medicare carriers responsible for processing part B claims in 9 geographic areas; three regional OIG Offices of Investigations with combined investigative jurisdiction over 17 states; one durable medical equipment regional carrier responsible for processing durable medical equipment, prosthetic, orthotic, and supply claims in 14 states and 2 U.S. territories; and trade associations representing both the nursing home industry and providers of services and supplies. Because information we obtained from the three Medicare carriers and OIG offices involves cases under active investigation, we did not disclose the locations of these offices nor did we reveal identifying details about these cases, such as the providers' names and the states in which they operate.

To examine the nature and extent of inappropriate and abusive billing for services and supplies to nursing facility patients, we (1) asked the carriers' fraud units to identify cases involving services and supplies provided to patients in nursing facilities--both ongoing cases and those referred to OIG in the previous 24 months;\17 (2) performed a detailed file review of each identified case and obtained and reviewed copies of relevant documents; (3) discussed cases with carrier officials, as needed, and met with OIG officials to discuss the status of cases that carriers had referred to them for investigation; and (4) asked OIG officials to identify any additional investigations completed within the previous 12 months and ongoing investigations dealing with services and supplies furnished to Medicare patients in nursing facilities. In all, we reviewed 70 ongoing or completed investigations. Nearly all of these investigations were initiated by either the carrier or OIG offices during the 1992 to 1994 time frame. We interviewed carrier and OIG officials. We also reviewed several independent studies related to the provision of services and supplies to nursing facility patients done by OIG and the Senate Special Committee on Aging.

To examine the reasons inappropriate and abusive billings for services and supplies occur in the nursing facility setting, we reviewed carrier case files for each investigation, obtained court documents when applicable, and interviewed carrier and OIG investigators working on those individual cases. We analyzed this information to try to identify the specific programmatic factors that make services for beneficiaries in nursing facilities vulnerable to fraud and abuse.

Finally, to identify options for removing opportunities for fraud and abuse, we reviewed the literature and held discussions with carrier, OIG, and trade association officials to solicit their views on ways to minimize fraud and abusive billing practices in the nursing facility environment.

We conducted our review between April 1994 and August 1995 in accordance with generally accepted government auditing standards.

\17 The carriers we visited could not reliably identify all cases under investigation that involved the provision of services and supplies by outside providers to nursing facility patients. Carriers, accordingly, had to rely on memory when we asked them to

identify such cases.

CLOSED FRAUD CASE SUMMARIES

===== Appendix II

Following are summaries of fraud cases that were closed by the time we completed our review. The defendants pled guilty or were convicted of the charges brought against them.

CASE A

----- Appendix II:1

In August 1991, a carrier received the first of three complaints from Medicare beneficiaries alleging that an optometrist was billing Medicare for more services than he actually provided. After reviewing the supporting medical records, however, the carrier determined that for these instances the services were documented as billed. In December 1991, another beneficiary called the carrier and stated that she had not received the office services claimed by this optometrist and in fact had not seen any physician during the month he claimed services were provided. Another complaint was received from the daughter of a beneficiary residing in a nursing home. The daughter stated that she had only authorized an eye examination, but the charges submitted to Medicare were for multiple services provided for both eyes--although her father had only one eye. In January 1992, the carrier's claims processing department alerted the carrier's program integrity unit of 98 suspicious claims submitted by this provider for services allegedly rendered in December to nursing home patients. All the claims cited exactly the same procedure codes and diagnoses; the only differences were dates of service and beneficiary identification information. From this universe, the carrier randomly sampled 10 beneficiary records from two nursing homes and found that the nursing homes had no records documenting the services claimed by this optometrist. On May 21, 1992, the carrier summarized this information and referred the case to OIG. By that time, Medicare had paid this provider \$117,534 since 1990.

OIG notified the carrier in June 1992 that it would not pursue this case criminally but that it would retain jurisdiction for civil prosecution. At OIG's request, the carrier placed this provider on 100-percent prepayment review by the end of July, which meant that every claim the provider submitted was reviewed before payment was issued. Additionally, the carrier completed a postpayment review on this provider's billings and reported in January 1993 that medical necessity appeared questionable for many claims and that nursing home visits and consultation requests were not documented. The optometrist requested a hearing before the Medicare hearing officer to review the carrier's continuing reimbursement denials. The hearing officer ruled in November 1993 that all 157 claims submitted for diagnostic eye services for 154 nursing home patients between August and October 1992 were questionable. The carrier had denied all but three of these claims, but the hearing officer ruled that these too were overpaid. According to carrier files, the optometrist was still on prepayment review in March 1994. Although the optometrist's billing volume had significantly decreased, the carrier noted that he continued to bill for the same type of procedures previously denied. As late as October 1994, the carrier was still receiving complaints about this provider.

On January 16, 1995, the optometrist signed a settlement agreement in U.S. District Court whereby he admitted to knowingly filing false, misleading, or otherwise fraudulent Medicare claims for services either not medically necessary or not provided from 1991 through 1993

for which Medicare had paid him over \$191,276. Under this agreement he would repay \$35,000 and be excluded from the Medicare program for at least 3 years. The exclusion would extend for as long as the \$35,000 assessed against him was not repaid.

CASE B

----- Appendix II:2

A beneficiary's husband complained to the Medicare carrier that a supplier was billing Medicare for more supplies than it actually provided for his wife. The carrier referred this case to OIG, which opened its investigation on December 7, 1990. The company in question focused on publicly funded facilities in several states, such as state veterans homes or state-funded chronic disease or long-term care hospitals. The owner would approach facility administrators and offer to provide supplies for Medicare patients at no cost to the facility. This was an attractive proposition to these facilities, which typically have limited financial resources. The facility administrators gave the provider complete access to patient medical records. The suppliers reviewed all records, identified Medicare beneficiaries, obtained their Medicare numbers, developed lists of supplies based on diagnoses, identified attending physicians, and made copies of signed physician orders in the files. The supplier then billed Medicare for ostomy, enteral, or surgical dressing supplies that it delivered after September 1990, but it also billed for supplies it had never delivered to those beneficiaries over the previous 2 years. The supplier provided certificates of medical necessity by forging the attending physicians' signatures on the certificates using samples of signed orders found in the patients' files. The case involved about 4,000 fraudulent claims totaling about \$1.5 million.

The defendant was indicted on April 6, 1994, and pled guilty on May 5, 1994, to mail fraud, engaging in monetary transactions in criminally derived property, money laundering, and Medicare fraud. The defendant agreed to forfeit all property resulting from these fraudulent transactions, including about \$328,000 in several bank accounts. The defendant was sentenced on October 19, 1994. This judgment was amended on November 21, 1994, to finalize the overpayment amounts. He was sentenced to 54 months in federal prison. Upon release from imprisonment, the defendant would be on supervised release for a term of 3 years provided he had made restitution as ordered by the court of \$971,000 to Medicare and \$60,000 to Medicaid.

CASE C

----- Appendix II:3

A Medicare carrier's fraud and abuse unit received over 30 complaints from beneficiaries, family members, and other informants that a provider was billing for supplies that had not been furnished or were not needed. In August 1991, the carrier referred the case to OIG for investigation. OIG found that from April through June 1991, the provider filed claims totaling \$666,560 on behalf of 1,096 beneficiaries for 65,833 liquid skin barriers. In addition, the provider filed claims totaling \$11,406 on behalf of 319 beneficiaries for 1,210 adhesive removers or solvents. Medicare had paid the provider a total of \$263,222 for both items, and most of the claims were for beneficiaries who were residing in nursing homes in another state. In addition to the payments made, the carrier was withholding payment on 9,500 claims totaling about \$3.5 million.

OIG visited the provider and found that the provider rented a small

office and apparently did not furnish any supplies from this location. The provider, in effect, was a storefront operation or shell company. OIG believed the supplies originated from the provider's parent company located in another state that also owns supply companies in at least six other states. On the basis of its investigation, OIG believed the provider had (1) billed Medicare for items that were not supplied, (2) misrepresented the items that were supplied, (3) misrepresented the place of service, (4) misrepresented the medical conditions of patients who received the supplies, and (5) paid kickbacks to nursing home officials to induce business. Also, OIG found that the provider gained access to patient medical records, obtaining diagnostic information and the names of beneficiaries' attending physicians. The provider then entered the physicians' names on claim forms; physician orders were often nonexistent. OIG concluded that the supplier served merely as a conduit for submitting claims to the Medicare carrier and receiving checks. The funds were then transferred to the parent company.

On April 24, 1995, an officer of the parent company pled guilty to submitting more than \$4.4 million of false and fraudulent claims to one Medicare carrier and similarly submitting millions of dollars worth of false and fraudulent claims to other Medicare carriers. The provider billed Medicare for supplies at inflated rates as well as for supplies that were not provided or not medically necessary--including billing supplies for patients who had died. In one instance, the provider billed Medicare \$2,790 for surgical dressing kits that were never provided; instead, the provider furnished the patient 62 gauze bandages costing less than \$20. Under a plea agreement, the officer of the company agreed to cooperate with federal authorities in their attempts to identify others involved in the conspiracy. In return, the U.S. Attorney will recommend a prison term not to exceed 15 months.

CASE D

----- Appendix II:4

After reviewing a Medicare explanation of benefits notice, a beneficiary's son questioned why his mother--a nursing home resident--received such large quantities of supplies. In investigating the matter, the Medicare carrier determined that the provider was billing for supplies that were not provided. OIG began its investigation in July 1990. On November 8, 1990, a federal grand jury returned a 623-count indictment against the two providers it alleged obtained payment for false, fictitious, and fraudulent claims submitted for approximately 120 nursing home patients in three facilities in different states. One supplier (supplier #1) submitted the false claims to the carrier knowing that the supplies had never been provided. Another supplier (supplier #2) had given supplier #1 billing information for the patients in the three nursing facilities--patient names, Medicare numbers, diagnoses, treating physicians, and so forth. As part of the conspiracy, supplier #2 received a kickback from supplier #1 equal to 50 percent of the money received from the carrier for the false claims. Between June 7 and August 8, 1990, the carrier paid about \$813,973 for false claims--an average of about \$6,783 per patient.

On September 30, 1991, as a result of plea-bargaining, supplier #2 pled guilty to one count of conspiracy to defraud the United States with respect to claims, one count of submitting false claims, and one count of mail fraud. On January 9, 1992, the vice president of supplier #2 was sentenced to 26 months in jail and ordered to repay \$75,000 to HHS and pay a special assessment of \$150. The company itself was also fined \$5,000 and ordered to pay a special assessment of \$100. On November 6, 1991, supplier #1 was found guilty after

trial of all 623 counts. On February 4, 1992, the president of supplier #1 was sentenced to 24 months of incarceration and ordered to repay \$300,000 to HHS and pay a special assessment of \$31,150. The company was also fined \$1,000 and ordered to pay a special assessment of \$62,200.

In November 1994, a civil case against supplier #1 was settled with a summary judgment. Supplier #1--which is out of business and bankrupt--was ordered to pay \$4,955,000. Toward this amount, the government applied the \$407,121 seized from the company's corporate account and has up to 30 years to recover the remainder of the funds from the president of the company.

CASE E

----- Appendix II:5

On February 3, 1992, a Medicare carrier received a complaint forwarded from the daughter of a beneficiary. The complaint concerned a wheelchair cushion that should have cost less than \$100 but that was charged to Medicare as a \$1,503 custom-fitted body jacket. After receiving several complaints from family members of other nursing home residents and nursing home staff, the carrier noted the increased billings by the supplier submitting this claim and started to review related nursing home records. Carrier medical staff determined that services the supplier billed Medicare for were not provided, beneficiaries were not measured for a custom fit, the beneficiaries' condition could not be improved by using the jackets, physical therapy was billed for but neither ordered nor received, and the physicians only signed prescriptions that had been prepared by someone else. By mid-May, the carrier had received 38 complaints against this supplier of which 34 pertained to body jackets. By mid-August, the inquiries concerning this supplier had increased to 50. The carrier referred this case to OIG on August 25, 1992.

OIG's investigation revealed that this supplier actually started marketing wheelchair cushions with adjustable straps as Medicare-reimbursable custom-fitted body jackets in 1991. Sales representatives for the supplier would market the body jackets to the directors of nursing as fully Medicare covered and promise that no real attempt would be made to collect the co-payments from the beneficiaries. They would offer to go into the nursing facility files to obtain the patient information needed to prepare claims and certificates of medical necessity. Usually, the facility allowed such access; in other cases, the facility provided the necessary information. In some cases, the supplier gained access to nursing homes by providing kickbacks in the form of payments on insurance policies or to individuals to induce them to order exclusively from this supplier.

The sales people obtained physicians' signatures on the certificates of medical necessity by assuring physicians that the director of nursing had requested the items and that the items would cost the patients nothing. The certificates would be sent to the supplier's headquarters, where employees would add or delete wording from the signed certificates to guarantee Medicare payment. By December 1992, Medicare had paid this supplier over \$1.6 million for wheelchair cushions misrepresented as body jackets.

Seven persons involved in this fraudulent scheme were indicted and pled guilty; all were sentenced in fall 1994. The owner of the company was sentenced to 33 months in jail followed by 3 years on supervised release and was ordered to make restitution to Medicare of \$386,508. Two other principal defendants connected with the firm were placed on probation for 5 years and each was ordered to make

restitution of \$386,508. Two persons convicted of receiving kickbacks were each placed on probation for 5 years and fined \$9,000 and \$10,000, respectively. (Two other defendants, who assisted in the investigation, pled guilty to lesser charges and executed agreements for pretrial diversion. Under these agreements, if they provided 100 hours of community service and abided by the conditions of the agreement, charges against them would be dismissed after 1 year and the record would be erased.)

CASE F

----- Appendix II:6

In September 1992, the granddaughter of a beneficiary reported to the carrier that her grandmother had never received a custom-fitted back brace (commonly referred to as a body jacket) that had been billed to Medicare by this supplier. One month later, a similar complaint was received from the husband of another beneficiary. The following month, the daughter of a third beneficiary wrote to the carrier complaining of a claim for a body jacket that her mother did not need or use. When she went to the nursing home, she learned that her mother and others had refused to accept the body jackets and the nursing home had put them in storage. After talking to the administrator and nurses at the home, the daughter learned that a representative of the supplier came to the nursing home, checked patients' records, and left forms to be completed for products the patients qualified for. This complainant stated that this supplier appeared to be operating out of a residence: there was no telephone listing for the company. In December, the daughter of another beneficiary wrote to the carrier complaining about the "ridiculous" charge for a body jacket that was provided without her knowledge or consent.

This supplier was established for the sole purpose of selling body jackets, which it sold primarily to nursing home patients. Company representatives went to nursing homes to sell wheelchair pads, which they asserted were reimbursable by Medicare. These representatives told nursing home personnel and beneficiaries that the beneficiaries would not be responsible for any costs not reimbursed by Medicare. The company representatives also prepared certificates of medical necessity for the wheelchair pads sold and obtained physicians' signatures. The company then billed Medicare for body jackets. According to carrier correspondence, this supplier had been reimbursed \$564,808 for body jackets from July 1, 1992, through December 31, 1993.

On March 24, 1993, the carrier referred this case to OIG, noting that on the basis of the allegations and information it had obtained, the body jackets billed did not appear to be customized and the prescriptions appeared to be completed by someone other than the listed physicians. In its referral letter, the carrier reported that this supplier had received nearly \$416,000 from Medicare during the last 6 months of 1992. All claims were for a \$1,289 body jacket.

On June 16, 1995, a plea agreement was filed in court in which the company pled guilty to one count of mail fraud and agreed to repay \$450,000 to Medicare. As part of the consideration for this plea agreement, the president of this company agreed to testify before grand juries or at trials on matters involving other persons under investigation for this same type of fraudulent scheme.

CASE G

----- Appendix II:7

A Medicare carrier's fraud and abuse unit began investigating a laboratory on January 29, 1991, on the basis of a complaint by a beneficiary's daughter. The daughter stated her mother did not order the services for which Medicare paid the laboratory \$142. Nor had the services been ordered by the beneficiary's doctor or the nursing home where the beneficiary resided. The carrier reviewed the pertinent medical records for 15 beneficiaries in three nursing homes in two different states and found that none of the services were medically necessary. For 14 beneficiaries, there were no physician orders requesting the services, and for the remaining beneficiary, the diagnosis submitted with the claim was not documented. The carrier identified an overpayment of \$10,520 for 19 claims paid during a 4-month period.

On August 13, 1991, the carrier referred this case to OIG for further investigation. Following this referral, the carrier received several additional complaints against this laboratory. For example, a beneficiary's legal guardian learned that Medicare paid the laboratory \$706 for the telephonic transmission of 21 electrocardiogram (EKG) rhythm strips over a 2-week period. She contacted the beneficiary's physician and learned that the physician did not authorize or have any prior knowledge of such tests. In another complaint, a former employee stated the laboratory's salespeople contacted doctors regarding its cardiac monitoring system. If doctors signed up for the service, they had to provide listings of their heart patients in nursing homes. The laboratory then sent people to the nursing homes to perform 21 EKGs on each patient over an 11-day period, with the series of tests to be repeated three more times during the year. The laboratory charged about \$1,000 per patient for the 11-day study, or about \$4,000 per year per patient. However, the doctors generally did not see the results of the studies. The laboratory operated all over the country; one doctor alone had 275 patients on this program.

As a result of its investigation, OIG concluded that most of the laboratory's billings for these services were inappropriate. OIG found that the laboratory was billing Medicare for EKGs that were rendered as routine screening diagnostic tests, with no evidence of a physician evaluation and no indication that the patients were experiencing an arrhythmia, symptom, or complaint. OIG pursued the case as a civil false claims case because the diagnoses entered on the Medicare claim forms by the laboratory were false--they did not accurately reflect the patients' conditions at the time the EKG services were ordered and rendered. OIG estimated that the actual Medicare overpayment in this case was about \$6 million.

On February 10, 1994, the laboratory and its three principal owners entered into an agreement to reimburse HHS \$250,000 plus \$16,118 in interest for inappropriate claims. In addition, the laboratory waived any future demands for \$655,086 in payments (identified through a special prepayment review effort) that the Medicare carrier had withheld--thus resulting in a total settlement of \$921,204. Finally, the provider and its three owners were excluded from participating in the Medicare program for a 5-year period effective February 10, 1994.

CASE H

----- Appendix II:8

The carrier initiated its review of this optometrist and the group optometry practice he owns on September 11, 1990. This review was based on a beneficiary's letter to the carrier dated July 7, 1990, alleging that the optometrist performed only an eye examination, not the surgery he had claimed and had been reimbursed for by Medicare.

By the time the carrier referred the case to OIG on July 30, 1991, it had received 19 complaints against the group practice and 2 against the individual; 19 of these complaints involved beneficiaries in nursing homes. The complaints alleged that the providers had billed Medicare for services that were never furnished or that were not necessary. According to a nursing home administrator, a representative of the group practice would visit nursing homes, review patient records, and obtain the necessary patient information to file Medicare claims. Several days later, an optometrist would visit the nursing home and render services.

After reviewing nursing home medical records for 20 beneficiaries, the carrier concluded that the services billed were not medically necessary or not documented. The provider submitted the same diagnosis and tests on all claims. The claims identified a referring physician and charges for consultations, but the records contained no orders requesting consultations. On May 15, 1992, OIG requested that the carrier place both the individual optometrist and the group practice on 100-percent prepayment review.

While this case was open, this optometrist wrote not only to the carrier but also to his congressional delegation alleging discrimination against him as an optometrist. He also enlisted the help of his patients to write to Medicare of his successes and to provide copies of those letters to their Congress Members and Senators. However, the case had nothing to do with the technical merits of his optometry practice. He was billing Medicare for services never rendered to patients and for consultations for which the medical files showed no physician requests. A civil settlement was signed on December 14, 1994, and filed in U.S. District Court on January 20, 1995. Although Medicare reimbursed this provider over \$451,617 based on false, misleading, or otherwise fraudulent claims, the settlement involved a refund of \$30,000 to be paid over a 35-month period and voluntary exclusion from the Medicare program for 3 years. If the defendant defaults on the financial obligation, the exclusion continues until the obligation is fully satisfied.

RELATED GAO PRODUCTS

===== Chapter 0

Fraud and Abuse: Medicare Continues to Be Vulnerable to Exploitation by Unscrupulous Providers (GAO/T-HEHS-96-7, Nov. 2, 1995).

Medicare: Modern Management Strategies Could Curb Fraud, Waste, and Abuse (GAO/T-HEHS-95-227, July 31, 1995).

Medicare: Adapting Private-Sector Techniques Could Curb Losses to Fraud and Abuse (GAO/T-HEHS-95-211, July 19, 1995).

Medicare: Rapid Spending Growth Calls for More Prudent Purchasing (GAO/T-HEHS-95-193, June 28, 1995).

Medicare: Modern Management Strategies Needed to Curb Program Exploitation (GAO/T-HEHS-95-183, June 15, 1995).

Medicare: Reducing Fraud and Abuse Can Save Billions (GAO/T-HEHS-95-157, May 16, 1995).

Medicare Claims Billing Abuse: Commercial Software Could Save Hundreds of Millions Annually (GAO/T-AIMD-95-133, May 5, 1995).

Medicare and Medicaid: Opportunities to Save Program Dollars by Reducing Fraud and Abuse (GAO/T-HEHS-95-110, Mar. 22, 1995).

Medicare: High Spending Growth Calls for Aggressive Action
(GAO/T-HEHS-95-75, Feb. 6, 1995).

*** End of document. ***

California Nursing Homes: Federal and State Oversight Inadequate to Protect Residents in Homes With Serious Care Violations (Testimony, 07/28/98, GAO/T-HEHS-98-219).

GAO discussed its findings on nursing home care in California, focusing on: (1) identified in recent state and federal quality reviews that California conducted in the last 2 or 3 years; (2) obstacles to federal and state efforts to identify care problems; and (3) implementation of federal enforcement policies to ensure that homes correct problems identified and then sustain compliance with federal requirements.

GAO noted that: (1) despite the presence of a considerable federal and state oversight infrastructure, a significant number of California nursing homes were not and currently are not sufficiently monitored to guarantee the safety and welfare of nursing home residents; (2) GAO came to this conclusion by using information from California's Department of Health Services (DHS) reviews of nursing home care covering 95 percent of the state's nursing homes and Health Care Financing Administration (HCFA) data on federal enforcement actions taken; (3) looking back at medical record information from 1993, GAO found that, of 62 resident cases sampled, residents in 34 cases received care that was unacceptable; (4) however, in the absence of autopsy information that establishes the cause of death, GAO cannot be conclusive about whether this unacceptable care may have contributed directly to individual deaths; (5) as for the extent of care problems currently, between July 1995 and February 1998, California surveyors cited 407 homes for care violations they classified as serious under federal or state deficiency categories; (6) moreover, GAO believes that the extent of current serious care problems portrayed in the federal and state data is likely to be understated; (7) the predictable timing of on-site reviews, the questionable accuracy and completeness of medical records, and the limited number of residents' care reviewed by surveyors in each home have each likely shielded some problems from surveyor scrutiny; (8) even when the state identifies serious deficiencies, the HCFA enforcement policies have not been effective in ensuring that the deficiencies are corrected and remain corrected; (9) California's DHS, consistent with HCFA's guidance on imposing sanctions, grants 98 percent of noncompliant homes a 30- to 45-day grace period to correct deficiencies without penalty, regardless of their past performance; (10) only the few homes that qualify as posing the greatest danger are not provided such a grace period; (11) in addition, only 16 of the roughly 1,400 California homes participating in Medicare and Medicaid have been terminated from participation, most of them have been reinstated quickly, and many have had subsequent compliance problems; and (12) recognizing shortcomings in enforcement, California officials told GAO that they launched a pilot program in July 1998 intended to target for increased vigilance certain of the state's nursing homes with the worst compliance records.

----- Indexing Terms -----

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Sanctions
Elderly persons
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Cover

===== COVER

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

For Release on Delivery
Expected at 10:00 a.m.
Tuesday, July 28, 1998

CALIFORNIA NURSING HOMES - FEDERAL
AND STATE OVERSIGHT INADEQUATE TO
PROTECT RESIDENTS IN HOMES WITH
SERIOUS CARE VIOLATIONS

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

GAO/T-HEHS-98-219

GAO/HEHS-98-219T

(101753)

Abbreviations

===== ABBREV

DHS - Department of Health Services
HCFA - Health Care Financing Administration
HHS - Department of Health and Human Services

OBRA87 - Omnibus Budget Reconciliation Act of 1987
OSCAR - On-Line Survey, Certification, and Reporting

CALIFORNIA NURSING HOMES: FEDERAL
AND STATE OVERSIGHT INADEQUATE TO
PROTECT RESIDENTS IN HOMES WITH
SERIOUS CARE VIOLATIONS

===== Chapter 0

Mr. Chairman and Members of the Committee:

Thank you for inviting me to discuss our findings on nursing home care in California. The federal government has a major stake in nursing home care, having paid the nation's roughly 17,000 homes \$28 billion in 1997 through the Medicare and Medicaid programs. While the public relies on nursing homes to provide care to one of the most vulnerable segments of our population, allegations were raised to your Committee that some 3,000 residents died in more than 900 California nursing homes in 1993 as a result of malnutrition, dehydration, sepsis from improperly treated urinary tract infections, and other serious conditions for which they did not receive acceptable care.

The information I am presenting today is based on our recently issued report to your Committee. Although I will begin with the care problems found through reviewing medical records for a sample of 62 residents who died in 1993, the majority of my comments will focus on our analysis of the current information on the quality of care in all California nursing homes. This analysis focused on care problems identified in recent state and federal quality reviews that California conducted in the last 2 or 3 years, obstacles to federal and state efforts to identify care problems, and implementation of federal enforcement policies to ensure that homes correct problems identified and then sustain compliance with federal requirements. The federal and state agencies with oversight responsibility for homes receiving funds from Medicare and Medicaid are the Health Care Financing Administration (HCFA) and the state of California's Department of Health Services (DHS). Together, they oversee care in the more than 1,400 California nursing homes, representing more than 141,000 resident beds. Medicare and Medicaid paid these homes approximately \$2 billion in 1997 to care for nursing home residents.

In brief, we found that despite the presence of a considerable federal and state oversight infrastructure, a significant number of California nursing homes were not and currently are not sufficiently monitored to guarantee the safety and welfare of nursing home residents. We came to this conclusion, for the most part, by using information from California's DHS reviews of nursing home care covering 95 percent of the state's nursing homes and HCFA data on federal enforcement actions taken.

Looking back at medical record information from 1993, we found that, of 62 resident cases sampled, 2 residents in 34 cases received care that was unacceptable. However, in the absence of autopsy information that establishes the cause of death, we cannot be conclusive about whether this unacceptable care may have contributed directly to individual deaths.

As for the extent of care problems currently, between July 1995 and February 1998, California surveyors cited 407 homes--nearly a third of the 1,370 homes in our analysis--for care violations they classified as serious under federal or state deficiency categories. Moreover, we believe that the extent of current serious care problems portrayed in these federal and state data is likely to be understated. The predictable timing of on-site reviews, the

questionable accuracy and completeness of medical records, and the limited number of residents whose care was reviewed by surveyors in each home have each likely shielded some problems from surveyor scrutiny.

Finally, even when the state identifies serious deficiencies, HCFA's enforcement policies have not been effective in ensuring that the deficiencies are corrected and remain corrected. For example, DHS surveyors cited about 1 in 11 California homes--accounting for over 17,000 resident beds--twice in consecutive annual reviews for violations involving harm to residents. (The national average was slightly worse--about one in nine homes were cited twice consecutively for violations of federal requirements involving harm to residents.) Nevertheless, HCFA generally took a lenient stance toward many of these homes. California's DHS, consistent with HCFA's guidance on imposing sanctions, grants 98 percent of noncompliant homes a 30- to 45-day grace period to correct deficiencies without penalty, regardless of their past performance. Only the few homes that qualify as posing the greatest danger are not provided such a grace period. In addition, only 16 of the roughly 1,400 California homes participating in Medicare and Medicaid have been terminated from participation, most of them have been reinstated quickly, and many have had subsequent compliance problems. Recognizing shortcomings in enforcement, California officials told us that they launched a pilot program this month intended to target for increased vigilance certain of the state's nursing homes with the worst compliance records.

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

\2 Our criteria for inclusion in the sample were that a case came from a home with at least 5 of the allegedly avoidable deaths and at least 5 such deaths per 100 beds. The 62 cases in our sample were drawn randomly and came from 15 nursing homes.

BACKGROUND

----- Chapter 0:1

The federal responsibility for overseeing nursing homes belongs to HCFA, an agency of the Department of Health and Human Services (HHS). Among other tasks, HCFA defines federal requirements for nursing home participation in Medicare and Medicaid and imposes sanctions against homes failing to meet these requirements. HCFA funds state survey agencies to do the on-site reviews of nursing homes' compliance with Medicare and Medicaid participation requirements. In California, DHS performs nursing home oversight, and its authority is specifically defined in state and federal law and regulations. As part of this role, DHS (1) licenses nursing homes to do business in California; (2) certifies to the federal government, by conducting reviews of nursing homes, that the homes are eligible for Medicare and Medicaid payment; and (3) investigates complaints about care provided in licensed homes. To assess nursing home compliance with federal and state laws and regulations, DHS relies on two types of reviews--the standard survey and the complaint investigation. The standard survey, which must be conducted no less than once every 15 months at each home, entails a team of state surveyors spending several days on site conducting a broad review of care and services with regard to meeting the assessed needs of the residents.\3 The complaint investigation involves conducting a targeted review with regard to a specific complaint filed against a home.

The state and HCFA each has its own system for classifying deficiencies that determines which remedies, sanctions, or other actions should be taken against a noncompliant home. For standard surveys, California's DHS typically cites deficiencies using HCFA's classification and sanctioning scheme; for complaint investigations, it generally uses the state's classification and penalty scheme.

Table 1 shows HCFA's classification of deficiencies and the accompanying levels of severity and compliance status.

Table 1

HCFA's Deficiency Classification System

HCFA deficiency category	Level of severity	Compliance status of home cited for this deficiency
Immediate jeopardy to resident health or safety	Most serious	Noncompliant
Actual harm that does not put resident in immediate jeopardy	Serious	Noncompliant
No actual harm, with potential for more than minimal harm	Less serious	Noncompliant
No actual harm, with potential for minimal harm	Minimal	Substantially compliant

HCFA guidance also classifies deficiencies by their scope, or prevalence, as follows: (1) isolated, defined as affecting a limited number of residents; (2) pattern, defined as affecting more than a limited number of residents; and (3) widespread, defined as affecting all or almost all residents.

\3 The standard survey is used not only to meet HCFA's certification requirement but also to ensure that a home continues to meet its state licensing requirements.

REVIEW OF RECORDS FOR 1993
DEATHS UNCOVERED SERIOUS CARE
PROBLEMS

Chapter 0:2

Our work indicates that 34 residents--more than half of our sample of 62 of California's nursing home residents who died in 1993--received unacceptable care. In certain of those cases, the unacceptable care endangered residents' health and safety; however, without an autopsy that establishes the cause of death, we cannot be conclusive about whether the unacceptable care directly led to any individual's death. Nevertheless, the care problems we identified were troubling, such as unplanned weight loss and failure to properly treat pressure sores. For example:

-- A resident lost 59 pounds--about one-third of his weight--over a

7-week period. Only a small share of the weight loss was attributable to fluid loss. Until 2 days before the resident's death, the nursing home staff had not recorded his weight since the day he was admitted to the home or notified the physician of the resident's condition.

- A resident was admitted to a nursing home with five pressure sores, four of which exposed the bone. Although the physician ordered pain medication during treatments that removed the blackened dead tissue from her sores, the resident's medical record indicated that she received pain medication only three times during 5 weeks of daily treatments. The resident, who was not in a condition to verbalize her needs, was reported in the nursing notes to moan whenever this procedure was done without prescribed pain medication.

STATE'S RECENT QUALITY REVIEWS
REVEAL SIGNIFICANT CARE
PROBLEMS IN NEARLY ONE-THIRD OF
ALL HOMES

----- Chapter 0:3

DHS surveyors identified a substantial number of homes with serious care problems through their annual standard surveys of nursing homes and through ad hoc complaint investigations. Our analysis of these data shows that, between 1995 and 1998, surveyors cited 407 homes, or nearly a third of the 1,370 homes included in our review, for serious violations classified under the federal deficiency categories, the state's categories, or both. (See fig. 1, "Caused Death or Serious Harm.") These homes were cited for improper care leading to death (26 homes), posing life-threatening harm to residents (259 homes), other serious violations involving improper care (111 homes), or falsifying or omitting key information from medical records (11 homes).

Figure 1: Distribution of
1,370 California Nursing Homes
by Seriousness of Violations
Cited, 1995-98

(See figure in printed
edition.)

The four wedges in figure 1 correspond to the federal deficiency categories shown in table 1 and include comparable-level deficiencies cited using the state's separate classification scheme, as shown in table 2.

Table 2

Categorization of Deficiencies by HCFA
and by California DHS

Description of deficiency categories	HCFA deficiency category	State deficiency category
Caused death or serious harm	Immediate jeopardy	Improper care leading to death, imminent danger or probability of death,
	Substandard care	intentional falsification of medical records, or material

omission in medical records.

Caused less serious harm	Actual harm	Violations of federal or state requirements that have a direct or immediate relationship to the health, safety, or security of a resident.
More than minimal deficiencies	Potential for minimal harm	California has no state citation directly equivalent to the federal category.
Minimal or no deficiencies	Potential for minimal harm/no deficiencies	California has no state citation directly equivalent to the federal category.

 Within the "caused death or serious harm" group are homes cited for several types of federal violations, including "improper care leading to death" and "life-threatening harm." Following is an example from the 26 homes California surveyors cited for improper care leading to death:\4

- A resident who was admitted to a home for physical therapy rehabilitation following hip surgery died 5 days later from septic shock, caused by a urinary tract infection. The home's staff failed to monitor fluid intake and urine output while the resident was catheterized and afterwards. Nursing home staff failed to notify a physician as the resident's condition deteriorated. When his family visited and found him unresponsive, they informed the staff and his physician was contacted. His physician ordered intravenous antibiotics, but the staff were unable to get the intravenous line in place and continuously functioning until 8 hours had passed. The resident died 3 hours later.

The next example is from the 259 homes California surveyors cited for life-threatening harm:

- Because the home lacked sufficient licensed nursing staff on duty, residents did not receive treatments, medications, or food supplements as ordered. One resident's medical record indicated that, although a licensed nurse had noted the individual's deteriorating physical condition a half hour before she died, there was no evidence that the nurse continued to assess the resident's vital signs, administered oxygen as prescribed by a physician's order, or notified the attending physician and family about the resident's deteriorating condition.

We also determined that cases of poor care were not limited to the 407 homes noted. State surveyors documented instances of serious quality problems that they categorized as federal deficiencies in the range of "actual harm" or "potential for more than minimal harm" or as lower-level state violations. Examples of these are included in our report.

 \4 The subclassification "improper care leading to death" does not include all residents who died in homes cited for violations related to residents' care, because the category "life-threatening harm" can also include such violations and associated deaths.

PREDICTABILITY OF SURVEYS,
QUESTIONABLE RECORDS, AND
SURVEY LIMITATIONS HINDER
EFFORTS TO IDENTIFY CARE
PROBLEMS

----- Chapter 0:4

The deficiencies that state surveyors identified and documented only partially capture the extent of care problems in California's homes, for several reasons. First, some homes can mask problems because they are able to predict the timing of annual reviews or because medical records sometimes misrepresent the care provided. In addition, state surveyors can miss identifying deficiencies because of limitations of the methods used in the annual review--methods established in HCFA guidance on conducting surveys--to identify potential areas of unacceptable care.

PREDICTABILITY OF ON-SITE
REVIEWS

----- Chapter 0:4.1

One problem masking the extent of poor care involves the scheduling of standard surveys. The law requires that a standard survey be unannounced and that it be conducted roughly every year.⁵ Because many California homes were reviewed in the same month--sometimes almost the same week--year after year, homes could often predict the timing of their next survey and prepare to reduce the level of problems that may normally exist at other times.

At two homes we visited, we observed that the homes' officials had made advance preparations--such as making a room ready for survey officials--indicating that they knew the approximate date and time of their upcoming oversight review. After we discussed these observations with California DHS officials, they acknowledged that a review of survey scheduling showed that the timing of some homes' surveys had not varied by more than a week or so for several cycles. DHS officials have since instructed district office managers to schedule surveys in a way that will reduce their predictability.

The issue of the predictable timing of surveys is long-standing. More than a decade ago, the Institute of Medicine called for adjusting the timing of the surveys to make them less predictable and maximize the element of surprise.⁶ Subsequently, the Omnibus Budget Reconciliation Act of 1987 (OBRA 87) nursing home legislation and HCFA's implementing guidance attempted to address the predictability issue. However, a subsequent HCFA-conducted poll of nursing home resident advocates in most states and a 1998 nine-state study by the National State Auditors Association found that predictable timing of inspections continues to be a problem.

⁵ Technically, the standard survey must begin no later than 15 months after the last day of the previous standard survey, and the statewide average interval between standard surveys must not exceed 12 months.

⁶ Institute of Medicine, Improving the Quality of Care in Nursing Homes (Washington D.C.: Institute of Medicine, 1986), pp. 32-33.

QUESTIONABLE RECORDS

----- Chapter 0:4.2

Inaccurate or otherwise misleading entries in medical records can mask care problems or make it more difficult for surveyors to prove that care problems exist. We found such irregularities among the medical records we reviewed, a problem widely recognized in long-term-care research.\7 Discrepancies appeared in about 29 percent of the 1993 records we reviewed. The following two examples of such discrepancies were found in these records:

- During the hospital stay of a nursing home resident, doctors discovered that the resident was suffering from a fractured leg and that the fracture had occurred at least 3 weeks before the hospitalization. The nursing home's records were missing the clinical notes for the same 3-week period preceding the resident's hospital stay, thus omitting any indication that an injury had occurred, how it might have occurred, or how it might have been treated.
- Although a resident's medical record showed that each day she consumed 100 percent of three high-caloric meals and drank four high-protein supplements, the resident lost 7 pounds--10 percent of her total weight\8 --in less than a month. The implausibility of the resident's weight loss under these conditions raises major questions about the accuracy of the medical records regarding nutritional intake.

California state surveyors have also identified serious discrepancies in medical records. The following example is one of the cases they cited:

- A home's treatment records named a staff member as having provided two residents with range-of-motion exercises nine separate times. It was later determined that the staff member was not working at the home when the treatments were reportedly provided.

\7 Jeanie Kayser-Jones and others, "Reliability of Percentage Figures Used to Record the Dietary Intake of Nursing Home Residents," Nursing Home Medicine, Vol. 5, No. 3 (Mar. 1997), pp. 69-76, and John F. Schnelle, Joseph G. Ouslander, and Patrice A. Cruise, "Policy Without Technology: A Barrier to Improving Nursing Home Care," The Gerontologist, Vol. 37, No. 4 (1997), pp. 527-32.

\8 According to medical experts, a 5-percent weight loss in a month is considered a significant loss.

HCFA'S PROTOCOL FOR
IDENTIFYING POTENTIAL CARE
PROBLEMS

----- Chapter 0:4.3

A third monitoring weakness that can hinder surveyors' detection of care problems involves HCFA's guidance on selecting cases for review to help surveyors identify potential instances and prevalence of poor care. HCFA policy establishes the procedures, or protocol, that surveyors must follow in conducting a home's standard survey. However, HCFA's protocol--designed to increase the likelihood of detecting problems with care--does not call for randomly selecting a sufficient sample of residents. Instead, it relies primarily on the use of the individual surveyor's professional expertise and judgment to identify resident cases for further review.

In contrast, our expert nurses, in reviewing current medical records to identify areas with potential for poor care, took a stratified random sample--cases from different groups of the home's more fragile as well as average residents. Each sample was of sufficient size to estimate the prevalence of problems identified. In addition, the nurses used a standard protocol to collect and record quality-of-care information from chart reviews, staff interviews, and data analyses to ensure that the information was in a consistent format across the various individuals interviewed and documents reviewed.

For two homes receiving their annual surveys, we compared the findings of the DHS surveyors, who followed HCFA's survey protocol, with the findings of our expert nurse team, who accompanied the state surveyors and conducted concurrent surveys. The methodology our expert nurses used examined primarily quality-of-care outcomes and related issues, whereas state surveyors, following federal guidance, reviewed this and 14 additional areas, such as social services, resident assessment, and transfer and discharge activities. As a result, DHS surveyors sought and found deficiencies in some important areas that our expert nurses did not document. However, in the quality-of-care area, our nurses found serious care problems that DHS surveyors did not find, including unaddressed weight loss, improper pressure sore treatment, and ineffective continence management.

HCFA'S ENFORCEMENT POLICIES
INEFFECTIVE IN BRINGING HOMES
WITH SERIOUS, REPEATED
VIOLATIONS INTO SUSTAINED
COMPLIANCE

----- Chapter 0:5

We also examined the efforts of the state and HCFA to ensure that the homes cited for serious deficiencies were correcting their problems and sustaining compliance with federal requirements over time. Encouraging sustained compliance and appropriately sanctioning deficient providers are among HCFA's stated enforcement goals. However, we found that, under HCFA's policies, enforcement results often fall far short of those goals.

Between July 1995 and March 1998, DHS surveyors cited 1 in 11 homes, or 122 homes, in both of their last two surveys for conditions causing actual harm, putting residents in immediate jeopardy, or causing death.⁹ These homes represent over 17,000 resident beds. The national compliance rate for about the same period and for the same repeated, serious harm deficiencies was slightly worse: about 1 in 9 homes, representing more than 232,000 beds, were cited.

However, HCFA enforcement policies have led to relatively few federal disciplinary actions taken against these homes in California. Before OBRA 87, the only sanction available to HCFA and the states to impose against such noncompliant homes, short of termination, was to deny federal program payments for new admissions. OBRA 87 provided for additional sanctions, such as denial of payment for all admissions, civil monetary penalties, and on-site oversight by the state ("state monitoring").¹⁰ Nevertheless, these sanctions were seldom applied, even to the 122 homes in our analysis cited twice consecutively for serious harm deficiencies. Specifically, only a fourth--33 homes--had any federal sanctions that actually took effect.

⁹ The data on deficiencies cited in standard surveys are contained in the OSCAR (On-Line Survey, Certification, and Reporting) System, a federal database maintained by HCFA.

\10 Other sanctions include third-party management of a home for a temporary period ("temporary management"); requirement for a home to follow a plan of correction developed by HCFA, the survey agency, or a temporary manager--with HCFA or survey agency approval--rather than by the home itself ("directed plan of correction"); and mandatory training of a home's staff on a particular issue ("directed in-service training").

HCFA POLICIES LEAD TO
LENIENT ENFORCEMENT STANCE

----- Chapter 0:5.1

HCFA's forgiving stance toward homes with a "ping-pong" history of compliance helps explain how these homes could repeatedly harm residents without facing sanctions. Generally speaking, HCFA sanctioning policy divides homes into two groups: those that the state agency is instructed to refer to HCFA immediately to initiate sanctioning and those for which the state agency is permitted to grant a grace period first to correct deficiencies without the imposition of federal sanctions.\11

To qualify for immediate referral under HCFA policy, homes must have been cited for deficiencies in the immediate jeopardy category or rated as a "poor performer." The criteria for meeting HCFA's poor performer definition include an intricate combination of immediate jeopardy and substandard quality-of-care deficiencies.\12 Since July 1995, when the federal enforcement scheme established in OBRA 87 took effect, 59 California nursing homes have been cited for immediate jeopardy deficiencies and about 25 have been designated poor performers. HCFA guidance permits the state to broaden the definition of poor performer, but California has chosen not to do so.\13

Noncompliant homes that are not classified in the immediate jeopardy or poor performer categories do not meet HCFA's criteria for immediate referral for sanctioning, even though some may have seriously harmed residents. HCFA policy permits granting a grace period to this group of noncompliant homes, regardless of their past performance. Between July 1995 and May 1998, California's DHS gave about 98 percent of noncompliant homes a grace period to correct deficiencies. For nearly the same period (July 1995 through April 1998), the rate nationwide of noncompliant homes receiving a grace period was higher--99 percent--indicating that the practice of granting a grace period to virtually all noncompliant homes is common across all states.

Following HCFA policy, DHS is not required to and does not appear to take into account a home's compliance history for the bulk of noncompliant homes receiving a grace period. Our report describes a home that, despite being cited by DHS for the same violations--the unacceptable treatment of pressure sores--4 years consecutively, has continued to receive a grace period to correct its deficiencies following each annual review. We question the wisdom of granting such homes a grace period with no further federal disciplinary action.

For the few California homes that have had federal sanctions imposed, HCFA has been less than vigilant. In principle, sanctions imposed against a home remain in effect until the home corrects the deficiencies cited and until state surveyors find, after an on-site review (called a "revisit") that the home has resumed substantial compliance status. However, if some of the home's deficiencies persist but are no more serious than those in the "potential for

harm" range, HCFA policy is to forgo a revisit and accept the home's own report of resumed compliance status. HCFA officials told us this policy was put into place because of resource constraints. In California, however, this policy has been applied even to some of the immediate referral homes that, on a prior revisit, had been found out of substantial compliance.

Our report describes the case of an immediate referral home for which HCFA twice accepted the home's self-reported statement of compliance without having DHS independently verify that the home had fully corrected its deficiencies:

- In an October 1996 survey, DHS cited the home for immediate jeopardy and actual harm violations, including improper pressure sore treatment, medication errors, insufficient nursing staff, and an inadequate infection control program. By early November 1996, however, surveyors had found in an on-site review that the problems had abated, although they had not fully ceased. A week later, the home reported itself to HCFA as having resumed substantial compliance.\14 HCFA accepted this report without further on-site review. About 6 months later (May 1997), in the home's next standard survey, DHS found violations that warranted designating the home as a poor performer. On a revisit to check compliance in July 1997, surveyors found new, but less serious, deficiencies. In August 1997, however, when the home reported itself in compliance, HCFA accepted the report without further verification. Between October 1996 and August 1997, HCFA imposed several sanctions but rescinded them each time it accepted the home's unverified report of resumed compliance status.\15

Similarly, HCFA's level of vigilance appears to be inadequate for homes that have been terminated and later reinstated. HCFA has the authority to terminate a home from participation in Medicare and Medicaid if the home fails to resume compliance. However, termination rarely occurs and is not as final as the term implies. In the recent past, California's terminated homes have rarely closed for good. Of the 16 homes terminated in the 1995 through 1998 time period, 14 have been reinstated. Eleven have been reinstated under the same ownership they had before termination. Of the 14 reinstated homes, at least 6 have been cited with new deficiencies that harmed residents since their reinstatement, such as failure to prevent avoidable accidents, failure to prevent avoidable weight loss, and improper treatment of pressure sores.

A home that applies for reinstatement is required to have two consecutive on-site reviews--called reasonable assurance surveys--within 6 months to determine whether the home is in substantial compliance with federal regulations before its eligibility to bill federal programs can be reinstated. HCFA officials told us that HCFA cannot prevent a home from being reinstated if it is in substantial compliance during these reviews. However, HCFA has not always ensured that homes are in substantial compliance before reinstating them. Consider the following example:

- A home terminated on April 15, 1997, had two reasonable assurance surveys on April 25 and May 28, 1997. Although the nursing home was not in substantial compliance at the time of the second survey, HCFA considered the deficiencies minor enough to reinstate the home on June 5, 1997. The consequence of termination--stopping reimbursement for the home's Medicare and Medicaid beneficiaries--was in effect for no longer than 3 weeks.\16 About 3 months after reinstatement, however, the home was cited for harming residents. DHS surveyors investigating a complaint found immediate jeopardy violations resulting from a

dangerously low number of staff. In addition, surveyors cited the home for providing substandard care. Dependent residents, some with pressure sores, were left sitting in urine and feces for long periods of time; some residents were not getting proper care for urinary tract infections; and surveyors cited the home's infection control program as inadequate.

\11 Homes in the immediate referral group do not necessarily receive sanctions. If homes come into substantial compliance before sanctioning is scheduled to take effect, HCFA rescinds the sanction.

\12 Under HCFA's definition of poor performer, a home must have been cited on its current standard survey for substandard quality of care and have been cited in one of its two previous standard surveys for substandard quality-of-care or immediate jeopardy violations. HCFA also has a special definition for "substandard quality of care," as follows: the deficiencies must constitute immediate jeopardy to resident health and safety in one of three categories of deficiencies, or belong to the same three categories and include the following combination of severity and scope levels: pattern of or widespread actual harm that is not immediate jeopardy, or widespread potential for more than minimal harm.

\13 For example, California could include in the poor performer definition a home's record of violations cited in the course of complaint investigations. Unlike standard surveys, complaint investigations are generally unexpected and provide surveyors a unique opportunity to gauge care issues in a home's everyday environment. Because these investigations can uncover serious quality-of-care problems, including complaint-generated violations in a home's poor performer record would give regulators a more complete picture of a home's compliance history.

\14 A home reports itself to HCFA as being in compliance by sending HCFA a letter called a "credible allegation of compliance."

\15 In the October 1996 survey, HCFA imposed a civil monetary penalty that went into effect October 3 and was stopped from further accrual on November 8 when HCFA determined that federal requirements were met, based on the survey that had found lower-level deficiencies. In the May 1997 standard survey, HCFA imposed a civil monetary penalty to take effect in May 1997 and a denial of payment for new admissions sanction to take effect in July 1997, both of which HCFA stopped in August 1997 when the home reported that it was in compliance.

\16 Under Medicare and Medicaid rules, terminated nursing homes may be paid for care of residents in the home on the date of termination for up to 30 days after the termination takes effect.

CALIFORNIA DHS IS PILOTING
ALTERNATIVE ENFORCEMENT
PROCEDURES TARGETING A SMALL
GROUP OF MOST SERIOUSLY
DEFICIENT HOMES

----- Chapter 0:5.2

California DHS officials recognized that the state--in combination with HCFA's regional office--has not dealt effectively with persistently and seriously noncompliant nursing homes. Therefore, beginning in July 1998 and with HCFA's approval, DHS began a "focused enforcement" process that combines state and federal authority and action, targeting providers with the worst compliance records for

special attention.

As a start, DHS has identified about 34 homes with the worst compliance histories--approximately 2 in each of its districts. Officials intend to conduct standard surveys of these homes about every 6 months, rather than the normal 9-to-15-month frequency. In addition, DHS expects to conduct more complete on-site reviews of homes for all complaints received about these homes. DHS officials also told us that the agency is developing procedures--consistent with HCFA regulations implementing OBRA 87 reforms--to ensure that, where appropriate, civil monetary penalties and other sanctions stronger than a corrective action plan will be used to bring such homes into compliance and keep them compliant. In addition, DHS has begun to screen the compliance history of homes by owner--both in California and nationally--before granting new licenses to operate nursing homes in the state. State officials told us that they will require all homes with the same owner to be in substantial compliance before any new licenses are granted.

CONCLUSIONS AND RECOMMENDATIONS

----- Chapter 0:6

The responsibility to protect nursing home residents, among the most vulnerable members of our society, rests with nursing homes and with HCFA and the states. In a number of cases, this responsibility has not been met in California. We and state surveyors found cases in which residents who needed help were not provided basic care--not helped to eat or drink; not kept dry, clean, or free from feces and urine; not repositioned to prevent pressure sores; not monitored for the development of urinary tract infections; and not given pain medication when needed.

As serious as the identified care problems are, many care problems may escape the scrutiny of surveyors. Homes can prepare for surveyors' annual visits because of their predictable timing. Homes can also adjust resident records to improve the overall impression of the home's care. In addition, DHS surveyors can overlook significant findings because the federal survey protocol they follow does not rely on an adequate sample for detecting potential problems and their prevalence. Together, these factors can mask significant care problems from the view of federal and state regulators.

HCFA needs to reconsider its forgiving stance toward homes with serious, recurring violations. Federal policies regarding a grace period to correct deficiencies and to accept a home's report of compliance without an on-site review can be useful policies, given resource constraints, when applied to homes with less serious problems. However, regardless of resource constraints, HCFA and DHS need to ensure that their oversight efforts are directed at homes with serious and recurring violations and that policies developed for homes with less serious problems are not applied to them.

Under current policies and practices, noncompliant homes that DHS identifies as having harmed or put residents in immediate danger have little incentive to sustain compliance, once achieved, because they may face no consequences for their next episode of noncompliance. Our findings regarding homes that repeatedly harmed residents or were reinstated after termination suggest that the goal of sustained compliance often eludes HCFA and DHS. Failure to bring such homes into compliance limits the ability of federal and state regulators to protect the welfare and safety of residents.

Our report makes recommendations to the HCFA Administrator to address these issues. Although our report focuses on selected nursing homes

in California, the problems we identified are indicative of systemic survey and enforcement weaknesses. Our recommendations therefore target federal guidance in general so that improvements are available to any state experiencing problems with seriously noncompliant homes. Thus, through HCFA's leadership, federal and state oversight of nursing homes can be strengthened nationally and residents nationwide can enjoy increased protection. In summary, we are recommending that HCFA revise its guidance to states in order to reduce the predictability of on-site reviews, possibly by staggering the schedule or segmenting the survey into two or more reviews; revise methods for sampling resident cases to better identify the potential for and prevalence of care problems; and, for those homes with a history of serious and repeated deficiencies, eliminate the offer of a grace period for resuming compliance and substantiate all of the home's reports of resumed compliance with an on-site review.

HCFA, DHS, and nursing home industry representatives have reviewed our report. Acknowledging that the findings were troubling, HCFA officials informed us that they are planning to make several modifications in their survey and enforcement process. DHS also suggested a number of changes--in addition to its new, focused enforcement program--intended to improve the federal survey and enforcement process. Last week, the administration announced a series of actions related to federal oversight of nursing homes, including night and weekend survey visits and increased inspection of homes with a record of noncompliance. HCFA, DHS, and industry representatives generally concurred with our recommendations, although both HCFA and DHS expressed some reservations about segmenting the standard survey. They contend that dividing the survey into two or more reviews would make it less effective and more expensive. However, we believe that this option--which could largely eliminate the predictability issue and increase the frequency of surveyors' presence at problem homes--warrants consideration of the benefits to be derived relative to the disadvantages that were raised.

Finally, despite the survey and enforcement modifications promised by HCFA and DHS, we remain concerned about the gap between stated goals and results. In 1995, HCFA enunciated its emphasis on encouraging sustained compliance and appropriately sanctioning deficient providers. Its practices since that time, however, argue for swift and significant changes, as illustrated in California by the persistence of problem homes with little federal sanctioning. We support the administration's recent initiative to strengthen the survey and enforcement process. However, we also believe that continued vigilance by the Congress is needed to ensure that the promised changes in federal and state oversight of nursing home care are implemented.

----- Chapter 0:6.1

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

*** End of document. ***

Date: Tuesday, July 21, 1998

FOR IMMEDIATE RELEASE

Contact: HCFA Press Office (202) 690-6145

Clinton Administration Announces New Initiatives To Improve The Quality Of Care In Nursing Homes

The Clinton Administration today announced a new **nursing** home care initiative to provide enhanced protections for **nursing** home residents and to target specific needed improvement in **nursing** home care.

Releasing an independent report that shows progress since strong **nursing** home enforcement regulations took effect in 1995, HHS Secretary Donna E. Shalala said additional steps will now be taken to address remaining problem areas, including those identified in the report.

The initiative announced today includes tougher enforcement of Medicare and Medicaid rules with strengthened oversight of **nursing** home quality and safety. Particular efforts will be aimed at preventing instances of bed sores, dehydration and nutrition problems.

"We must ensure that all Americans can rely on quality, compassionate care when they or a loved one requires **nursing** home care," Secretary Shalala said. "We have seen clear evidence of improvement, but we can and must do more to improve the lives of **nursing** home residents."

Since 1995, the Clinton Administration has been enforcing the toughest **nursing** home regulations in the history of Medicare and Medicaid. The new report to Congress notes significant improvements since 1995 in the quality of care delivered in **nursing homes**, including more appropriate use of physical restraints, anti-psychotic drugs, anti-depressants, urinary catheters and hearing aids. But the report also found a need for further improvements by states, **nursing homes** and others.

The steps unveiled Tuesday continue the Administration's efforts to improve the quality of life and care for **nursing** home residents. The Administration's initiative includes a wide range of new approaches to improve care:

- **Nursing homes** found guilty of a second offense for violations that harm residents will face sanctions without a grace period to allow them to correct problems and avoid penalties.
- **Nursing** home inspections will be conducted more frequently for repeat offenders with serious violations without decreasing inspections at other facilities. Inspection times will be staggered, with a set amount done on weekends and evenings.
- HCFA will instruct states to impose civil monetary penalties for each instance of serious or chronic violation. Until now, penalties have been linked only to the number of days a facility was out of compliance with regulations.
- Federal and state officials will focus their enforcement efforts on **nursing homes** within chains that have a record of non-compliance with federal rules.
- HCFA will provide additional training and other assistance to inspectors in states that are not adequately protecting residents. HCFA will enhance its review of the surveys conducted by the states and implement standard evaluation protocols.
- States that fail to adequately perform survey would lose federal funding for **nursing** home surveys. HCFA will contract instead with other entities to conduct survey and certification activities.

- HCFA will step up its review of **nursing homes'** ability to prevent bed sores, dehydration, and malnutrition. HCFA also will work with the Administration on Aging, the American Dietetic Association, clinicians, consumers, and **nursing homes**, to share best practices for residents at risk of weight loss and dehydration.
- State inspectors will review each **nursing** home's system to prevent, identify, and stop physical or verbal abuse, neglect, and misappropriation of resident property. A description of each **nursing** home's abuse prevention plan will be shared with residents and their families.
- HCFA will work with the HHS Inspector General and the Department of Justice to ensure that state survey agencies and others refer appropriate cases for prosecution under federal civil and criminal statutes, particularly cases that result in harm to patients.
- Individual **nursing** home survey results and violation records will be posted on the Internet to increase accountability and make information more accessible.

In addition to these administrative steps, the Administration will ask Congress for new legislative authority to help improve **nursing** home care and safety. Those requests include a requirement for criminal background checks of **nursing** home workers; allowing more workers with proper training to perform crucial nutrition and hydration functions; and to reauthorize a strong **nursing** home ombudsman program through HHS' Administration on Aging.

"We are confident that these actions will further improve the quality of residents' lives and our ability to detect problems with care in the future," HCFA Administrator Nancy-Ann DeParle said. "**Nursing** home residents will live with the dignity that they and their families deserve and expect." Resources for these efforts are included in the President's fiscal year 1999 budget request now pending in Congress.

About 1.6 million elderly and disabled people receive care in approximately 16,800 **nursing homes** across the United States. The federal government, through the Medicare and Medicaid programs, provides funding to the states to conduct on-site inspections of **nursing homes** participating in Medicare and Medicaid and to recommend sanctions against those that are violating health and safety rules.

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Note: HHS press releases are available on the World Wide Web at: <http://www.hhs.gov>.

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release

July 21, 1998

REMARKS BY THE PRESIDENT
IN HEALTH CARE ANNOUNCEMENT

The Oval Office

3:16 P.M. EDT

THE PRESIDENT: Thank you, Secretary Shalala, and Nancy Ann DeParle, and the advocates who are here. I wish your mother were here, Secretary Shalala. I have met her, and even a skeptical press corps would believe your account of her in full if they could see her.

The duty we owe to our parents is one of the most sacred duties we, as Americans, owe to each other. Nowhere is that duty more important than when a family makes the choice to move a parent into a nursing home. When that time comes, all of us need to know that all our parents will be well cared for.

Today, more than 1.6 million Americans live in more than 16,000 nursing homes nationwide. When the baby boom generation moves into retirement, the number will rise even higher. By 2030, the number of Americans over the age of 85 will double, making compassionate quality nursing home care even more important.

At their best, nursing homes can be a Godsend for older Americans and their families, providing a safe haven in times of need. But at their worst, they can actually endanger their residents, subjecting them to the worst kinds of abuse and neglect. For nearly six years, as Secretary Shalala said, we've worked hard to give our most vulnerable citizens the security and health services they need to live in peace and safety.

I am committed to honoring the great social compact between the generations, first let me say, by reserving every penny of the budget surplus until we save Social Security first. The historic balanced budget I signed last summer preserves the Medicare trust fund into the 21st century. We've taken action to root out Medicare fraud and abuse, saving taxpayers over \$20 billion.

Finally, we're fighting to meet the challenge of our changing health system by enacting a patients' bill of rights, to include access to specialists and the right to appeal health care decisions. I have extended those rights already to Medicare beneficiaries; they should be the rights of every American.

One of the most important way we can help our senior citizens is by improving the quality of care in our nursing homes. In 1995, when Congress tried to eliminate federal assurances of nursing home quality, I said no. It was the right thing to do. That same year, we put into place tough regulations to crack down on abuse and neglect in our nursing homes. Since then we have made real progress, as Secretary Shalala said, stepping up on-site inspections and helping nursing homes to find and fix problems.

As the HCFA report Secretary Shalala talked about shows all too clearly, however, the job is far from over. When people living in nursing homes have as much fear from dehydration and poor nutrition as they do from the diseases of old age, when families must worry as much about a loved one in a nursing home as one living alone, then we are failing our parents and we must do more.

Today, I'm acting within my power as President to crack down on unsafe nursing homes. Effective immediately, HCFA will require states to step up investigations of nursing homes, making on-site inspections more frequent and less predictable, so there is no time to hide neglect and abuse. Whenever we find evidence that a nursing home is failing to provide its residents with proper care, or even mistreating them, we will fine that facility on the spot. And if state enforcement agencies don't do enough to monitor nursing home quality, we will cut off their contracts and find someone else who will do the job right.

I'll continue to do everything I can to fight nursing home abuse and neglect, and to give more options to elderly, disabled, and chronically-ill Americans who choose to stay at home. But Congress also must act. This week I am proposing comprehensive legislation to protect older Americans with a national registry to track nursing home employees down known to abuse nursing home residents, and criminal background checks to keep potentially abusive employees from being hired in the first place. I ask the Congress to put progress ahead of partisanship on this issue, and pass this legislation to improve our nation's nursing homes this year.

Choosing to move a parent or a loved one into a nursing home is one of life's most difficult decisions. But with these steps we can at least give families a greater sense of security in knowing we are doing everything we possibly can to make our nursing homes safe and secure.

Thank you very much.

Q Do you think the Congress would be against the registry, per se?

THE PRESIDENT: No, I have no reason to believe they would be, and I hope they would pass it.

Q What do you mean by putting partisanship aside?

THE PRESIDENT: Well, we haven't had a lot of bills coming out of Congress this year, but I hope very much that they will pass this. I don't believe -- not since 1995, when there was an attempt to strip the federal authority standards has there been a serious move on this issue. And I believe there are a lot of Republicans, as well as Democrats, in Congress who will support this. So I'm quite hopeful that it will pass.

Q How about the patients' bill of rights; do you think you're going to get that?

THE PRESIDENT: Well, I don't know. That's up to them. We have to have some significant amount of Republican support to get a strong bill. We have to have 60 votes to break a filibuster in the Senate, and obviously a majority in the House, sufficient to actually make sure the bill could come to a vote. But we're still working on it and it's terribly important.

Everywhere I go in the country -- you know, I was just home last weekend and I was stunned at the number of people who came up to me and just started talking about it, and talking about their own experiences and how important they thought it was. So I'm very hopeful we'll get it.

Q How can you parlay that, then, into a real public response?

THE PRESIDENT: Well, I'm working at it. We've had a lot of events on the patients' bill of rights. I'm trying to get the public involved in this, trying to get them to express their opinions to their members of Congress and I will continue to do so.

Q I wanted to ask you about another issue, sir. Now that the Secret Service agents have testified, are you concerned about what they might be saying, one; and, two, do you find yourself holding them more at arm's length, sir?

THE PRESIDENT: The Secret Service has made its own decisions about what to say and how to do it, based on their professional sense of responsibility, and I'm not going to get into this. I've refused to comment on it so far and I'm going to continue to refuse to comment.

Q Mr. President, your administration is making a new push to end the standoff with Libya over the Lockerbie bombing, including possibly holding a trial in a neutral country, under U.S. or Scottish jurisdiction. Are you optimistic that this climate might help and what has brought on this new push?

THE PRESIDENT: Well, we have always said that our first goal was to bring the perpetrators of Pan Am 103 murders to justice. That's our first purpose. And since I got here we've been looking for ways to do that. We have had conversations with representatives of the British government, as well. We've always said we thought that there had to be a trial under American or Scottish law. There may be some possibility of standing up a Scottish court in another country, but there are lots of difficulties with it as well, apparently.

All I can tell you is that it's one of the things that we have explored with a view toward accelerating the day -- it's been a long time now, it's been a lot of years since that terrible day when Pan Am 103 crashed over Lockerbie. And we're looking at it, but I don't know that it can be done. Our people have spent a lot of time on it. We've talked to the British at great length about it. We're trying to find some way that has real integrity, that will work. But there are all kinds of practical difficulties that I'm sure our folks can explain. I don't know if we can do it, but we're working on it.

Q What brought it up now? I mean, what all of a sudden, after so many years?

THE PRESIDENT: I don't know why it is just now coming into the press. But it's not just being brought up now. We have literally been working for years; I have personally been engaged in this for years, trying to find a way to get the suspects out of Libya, into a court where we thought an honest and fair and adequate trial could occur.

And in a case like this, like every other case, as the years go by you run more and more chances that something will happen to the evidence that is available, to any witnesses that might be available. So we've had a sense of urgency about this for some time. But my guess is that it has come to public light because a significant number of conversations have had to be held between the American and the British authorities and between others in potential third-party venues, like the Netherlands. And I know there's been some discussion of that. But it has not been resolved yet.

Thank you.

Q Is there any indication that the Libyans might go on, sir?

Q Sir, can you comment on CNN's nerve gas report, that the Pentagon --

THE PRESIDENT: All I know is what Secretary Cohen has said to you, to the public and to me, which is that their view is that it did not occur.

Thank you all very much.

END

3:29 P.M. EDT

AGENDA
Nursing Home Initiative Status Report
December 9, 1998

- I. Status of the Implementation of the Nursing Home Initiative
- II. Status of the Department of Justice/HCFA Collaboration on the 22 Point Plan
- III. Nursing Home Commission



Office of the Administrator
Washington, D.C. 20201

NOV 16 1998

The Honorable Charles E. Grassley
Chairman
Senate Special Committee on Aging
Washington, D.C. 20510-6400

Dear Mr. Chairman:

I am responding to your letter of October 22 about our initiative to improve the quality of our nursing home care, and also updating you on the status of our efforts as of November 15. The nursing home initiative continues to be a top priority for HCFA, and I appreciate the support and leadership you have provided. I have addressed your comments in the October 22 letter in the order in which you raised them.

A1. Materials Provided

We have enclosed copies of the material you specifically requested, including the draft manual instructions that provide guidance to the States on the new Federal Monitoring System, and the August 20, 1998 memorandum to Regional Offices and States clarifying our revisit policy. The Health Care Financing Administration (HCFA) will continue to provide you with copies of any other material that is prepared in response to the nursing home initiative.

A2. Focused Enforcement

As I mentioned in my last update, our goal is to develop a fair and objective method of determining which facilities should be the focus of more intense scrutiny. HCFA developed a list of nursing homes that we proposed for focused enforcement to the States at the end of September. The States provided us with valuable comments on additional sources of data, e.g., the use of substantiated complaints, that we could use in selecting "special focus facilities." We continue to work with the State agencies to refine the methodology, and to select the nursing homes that should receive focused enforcement.

I will be happy to provide you with a copy of the final list when we have finished this process, but you should know that we do not plan a public announcement of the list. I had initially thought it would be a good idea to publish the list (to reassure the public that

HCFA and the states are working to enforce the law), but I have had several discussions with beneficiary advocates who have persuaded me otherwise. They argue that publicizing such a list could have the effect of: 1) unnecessarily frightening families with loved ones in the special focus facilities, or 2) allowing facilities not on the list to claim that they are getting our seal of approval. We would like to meet with you to discuss these issues once the final list is developed.

A3. Civil Monetary Penalties (CMPs)

We have requested that all regional offices contact the States in their respective Region in order to provide us with the following information relative to the distribution of collected CMPs: 1) the amount of money collected by the State in response to imposition of a CMP; 2) how the money collected has been used; and, 3) an indication as to whether or not any of the money collected has been returned to the State's general funds. We are awaiting the responses and will provide this information when we can.

A4. Alternatives

Sections 1819(h) and 1919(h) of the Social Security Act establish alternative remedies that can be used *instead* of terminating a nursing home's participation in our programs. Proceeding in another direction, i.e., implementing options other than those provided for in the Act, would require a statutory change or demonstration approval. However, I have discussed this idea with Dr. Harriet Fields, the State monitor for D.C. Village, and we are exploring the possibility of a demonstration to determine whether intense State monitoring in a few facilities that have indicated through inadequate performance that they need assistance would be effective. I will continue to keep you apprised of this possibility as well as any others that fall within our current statutory authority.

A6. The Federal Monitoring System and Abt Associates

We have scheduled two briefings for the Committee, one by David Zimmerman, Ph.D, and Andrew Kramer, M.D., on the development of the quality indicators, and another by Abt Associates on their activities to ensure the integrity of the Minimum Data Set (MDS) and related protocols. Both briefings have been coordinated with your staff and are scheduled for November 30.

A7. Appropriate Personnel

As requested, we have included the name of lead staff and their telephone numbers with each initiative listed on the implementation schedule (see enclosure).

B1. HCFA1(c)

We presented a list of nursing homes that we proposed for focused enforcement to the States at the end of September. The States provided us with valuable comments on additional sources of data--particularly the use of substantiated complaints--that we could use in selecting "special focus facilities." We have continued to work with State agencies to refine the methodology for selecting the nursing homes that should received focused enforcement.

B2. HCFA2(b)

The new Federal Monitoring System (FMS) was transmitted electronically and mailed to all HCFA regional offices, and copies were sent to the President, Association of Health Facility Survey Agencies, to share with the States (see enclosure). I also discussed our plans with representatives of state survey agencies, beneficiary advocates, and others in meetings held in August, September, and October.

C. Sufficient Staffing

The recent nursing home Report to Congress, the GAO report and testimony before your Committee, made clear that inadequate nurse staffing may be a root cause of many of the problems faced by nursing home residents. We are in the process of reviewing the relationship between staffing levels and the quality of care for nursing home residents. Accordingly, on September 28, 1998, a contract modification was awarded to our independent evaluation contractor, Abt Associates, to assist us in completing a comprehensive nurse staffing study. Current plans call for all the analyses to be completed and a report delivered to the Director, Disabled and Elderly Health Programs Group, HCFA, in 12 months, i.e., by September 30, 1999, and then submitted to the Congress by the end of the year.

This comprehensive nurse staffing study will help HCFA determine: 1) if minimum nurse staffing ratios are appropriate; and, if appropriate, 2) the potential cost and budgetary implications of minimum ratio requirements.

D. Budget Implications

We appreciate the decision by Congress, and your support in particular, to approve the FY 1999 funding the President proposed for survey and certification, and for appropriating an additional \$4 million to help fund the nursing home initiatives. The FY 1999 Survey and Certification budget included the first significant increase in survey and certification funding in a number of years and sends a positive message to all: the

Administration and the Congress are committed to assuring that the best care is purchased and provided for some of our most vulnerable citizens. Congress' concern is reinforced by its commitment to appropriately fund the mandated Federal/State oversight functions of survey and certification.

With the FY 1999 budget of \$171 million, we will continue to improve Federal and State oversight of the care provided in the numerous health care settings by the various care givers, especially nursing homes. While the \$13 million increase requested was originally intended to permit an improvement of the oversight efforts of other non-long term care providers through increased survey coverage levels, we will be channeling a portion of those funds, plus the \$4 million Congress specifically appropriated, to the implementation of our nursing home initiatives.

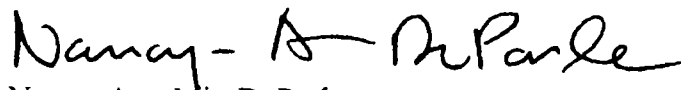
I am committed to funding this initiative adequately. As I have said before, however, even with this increased funding, we will need to allocate carefully and phase in the implementation of some of the pieces of our initiative. For instance, while we have changed the definition of "poor performing facility" to one that should be more effective, we expect that the State resource requirements would be higher if we were to schedule full implementation beginning right now. We believe that states will eventually incur additional administrative costs as a result of the tougher definitions because there will be more appeals by facilities. I think that phasing in these policies makes sense, given the magnitude of this entire initiative and the changes we are asking States to make. Thus, we are asking the States to phase in the new decision criteria for poor performers so that full implementation will not affect State surveyor and appeals processes until the end of the fiscal year.

We are in the process of finalizing our FY 1999 spending estimates and allocations. We would be happy to provide you with more information on this as soon as we can. We expect to improve the process and tools, the enforcement of regulations and the Federal oversight mechanism, all integral parts in our quest to improve the quality of care provided to nursing home residents. To further reinforce our collective efforts to improve the quality of health care, I will recommend that the Administration's FY 2000 survey and certification budget recognize the very real needs of the survey and certification program for Nursing Homes, Intermediate Care Facilities for the Mentally Retarded, Home Health Agencies and the many other providers for whom HCFA has oversight responsibility. We appreciate the support that Congress and your Committee have provided this year. Working with the Senate Select Committee on Aging, I expect HCFA to make great strides in accomplishing good things in the health care delivery arena.

Page 5 -- Mr. Chairman

I hope the information provided adequately responds to your concerns.

Sincerely,

A handwritten signature in black ink, appearing to read "Nancy-Ann Min DeParle". The signature is fluid and cursive, with a large initial "N" and a stylized "A" for "Ann".

Nancy-Ann Min DeParle
Administrator

Enclosures

NURSING HOME IMPLEMENTATION SCHEDULE

Project	Completion Dates	Lead (in bold)	Status
GAO Recommendations			
GAO-1.. Stagger Survey Schedules ▶ Working draft manual instructions • Clearance draft manual instructions ▶ Final manual instructions (same as HCFA-1(d))	Completed 11/30/98 12/31/98	CMSO (Cindy Graunke) 410-786-6782 Partners: OCOS; OGC; state govts; RO	Draft manual instructions prepared; analyzing comments.
GAO-2. Increase the Sample Size for Nutrition, Dehydration & Pressure Sore Areas ▶ Develop revised survey task for sampling methodology during surveys. ▶ Final State Operations Manual Instruction ▶ Develop protocol using quality indicators for pressure sores, malnutrition & dehydration	12/31/98 2/28/99 4/30/99	CMSO (Cindy Graunke) 410-786-6782 OCSQ (John Thomas) 410-786-2908 Partners: OCOS, RO	Contract let with University of Colorado (Andy Kramer), CHSRA (David Zimmerman), and Alpine Technology on 9/22/98.
GAO-3. Eliminate Grace Period for Homes with Repeated Serious Violations and Impose Remedies Promptly ▶ Release memo ▶ Working draft manual instructions • Clearance draft manual instructions ▶ Final State Operations Manual	Completed 2/28/99 3/31/99 4/30/99	CMSO (Cindy Graunke) 410-786-6782 Partners: OCOS, RO	Memo phasing in policy sent out 9/25/98.

NURSING HOME IMPLEMENTATION SCHEDULE

Project	Completion Dates	Lead (in bold)	Status
GAO-4. Define HCFA's "Revisit" Policy and Ensure Compliance Issue Policy Letter to all ROs/States on the revisit policy	Completed	CMSO (Cindy Graunke) 410-786-6782 Partners: OCOS, RO	Memo to ROs & States on 8/20/98 clarifying revisit policy.
Presidential Initiatives			
HCFA-1(a). Redefine "Poor Performing" Facility - Issue memo - Working draft guidance - Clearance draft manual instructions - Final State Operations Manual	Completed 2/28/99 3/31/99 4/30/99	CMSO (Cindy Graunke) 410-786-6782 Partners: OCOS, RO	Same status as GAO-3.
HCFA-1(b). Propose CMPs for "Each Instance" - Draft final regulation to HCFA's Regulations Staff - Publish final regulation with comment - Working draft manual instructions - Clearance draft manual instructions - Final manual instructions	Completed 12/31/98 1/31/99 2/28/99 3/31/99	CMSO (Cindy Graunke) 410-786-6782 Partners: OCOS, OGC; RO	Regulation sent to HCFA's Regulations Staff on 9/18/98. Regs team met on 11/2/98, 11/4/98, and 11/10/98. Team revisions have been incorporated and will be returned to the Regulations Staff the week of 11/16/98.
HCFA-1(c). Enhanced Monitoring of Special Focus Facilities (SFF) - List of facilities (by State) developed by CO - RO/States review list and make recommendations for appropriate revisions - Final list and protocol developed - States begin enhanced monitoring	Completed 11/30/98	CMSO (Cindy Graunke) 410-786-6782 Partners: providers; advocates; states, RO; health care professionals	Completed compiling SFF, draft protocol, monitoring and how to get off list; pro/con paper attached.

NURSING HOME IMPLEMENTATION SCHEDULE

Project	Completion Dates	Lead (in bold)	Status
HCFA-1(d). Stagger Nursing Home Inspections (same as GAO-1 above)			
HCFA-1(e). Define "Poor Performing Nursing Home Chain" and Consequences - Working draft manual instructions - Clearance draft manual instruction - Review and comment - Final State Operations Manual	11/30/98 12/31/98 1/31/99 2/28/99	CMSO (Cindy Graunke) 410-786-6782 Partners: CMSO/DSG; OIS; OCOS; OGC; RO	Memo sent to States/ROs on 9/25/98. Guidance and strategy outline developed through RO/CO workgroup, and sent out for comment.
HCFA-2(a). Provide Additional Training and Assistance to Inspectors that are not adequately protecting residents & Terminate Funding to States that fail to adequately perform survey functions or fail to improve inadequate survey systems. - Convene workgroup to develop criteria - Working draft manual instructions - Clearance draft manual instruction - Final State Operations Manual (Cases with State inadequate performance will be handled on a case-by-case basis prior to publication of criteria)	Completed 11/30/98 12/31/98 1/31/99	CMSO (Cindy Graunke) 410-786-6782 Partners: states; RO; CMSO/DEHPG/DOI; OCOS; OGC; ASPE	RO/CO workgroup convened on October 6 to begin working on criteria. Workgroup is scheduled to have a face-to-face meeting 11/30/98-12/1/98 and is looking into the 1864 agreement. Since the issues are more complex & require more research than originally anticipated, we've adjusted the 10/31/98 date to 11/30/98 to reflect a more realistic projection of time needed for this task.
HCFA-2(b). New Federal Monitoring System - Draft FMS protocols - Review and comment - Final FMS protocols - Training - Implementation - Information reporting system in place	Completed Completed Completed Completed Completed Completed	CMSO (Cindy Graunke) 410-786-6782 Partner: RO	PictureTel training on 9/25/98; over 100 RO staff trained. Train-the-Trainer held October 14-16 in Chicago for data collection and reporting.

NURSING HOME IMPLEMENTATION SCHEDULE

Project	Completion Dates	Lead (in bold)	Status
HCFA-3(a). Repository of Best Practices Guidelines for Caring for Residents at Risk of Weight Loss and Dehydration ▶ Solicit ideas through the "Sharing Innovations In Quality" Network ▶ Approval of ideas to be included ▶ Post on HCFA's Internet Approved Best Practice Guidelines	Completed Completed 12/31/98	CMSO (Cindy Graunke) 410-786-6782 OCSQ Partners: providers, advocates; States; health care professionals; RO	"Sharing Innovations in Quality" workgroup meeting held September 17-18; ideas from the field on nutrition and ADA guidelines; idea guidelines will be posted on a separate page from the clinical guidelines on HCFA's website. HCFA participated in an effort led by ADA on 11/6/98 in Washington, D.C.
HCFA-3(b). National Campaign to Increase Awareness on Prevention of Malnutrition & Dehydration ▶ RO participants identified ▶ Develop promotional themes & plan • Get feedback on plan from partners ▶ Focus test messages; Campaign begins • Print & distribute messages to targeted audiences	Completed 11/30/98 12/31/98 1/31/99 2/29/99	CBS (Michael McMullan) 410-786-4280 Partners: CMSO/DEHPG/DOI; OCSQ; RO; OCOS; DHHS	Workgroup members designated. Conducting inventory of existing materials from States for key message development.
HCFA-3(c). Clearer Guidance on Key Quality of Life/Quality of Care Issues (Including Nutrition, Hydration, Pressure Sores and Admissions Contracts) ▶ Draft interpretive guidelines ▶ Review and comment from ROs/States/Professional/Advocates/Industry • Clearance draft interpretive guidelines ▶ Final interpretive guidelines	Completed 11/30/98 1/31/99 4/30/99	CMSO (Cindy Graunke) 410-786-6782 Partners: OCSQ; OCOS; ASPE; providers; advocates; states; RO; health care professionals	Meeting held with contractor on 11/4/98 to discuss 4/99 product. Contractor will present automating concepts on 11/17/98 and 11/18/98. We had originally contemplated written guidelines and are now, through a contractor, pursuing automated ones. Draft interpretive guidelines given to contractor.

NURSING HOME IMPLEMENTATION SCHEDULE

Project	Completion Dates	Lead (in bold)	Status
HCFA-3(d) Using Effective Drugs ▶ Working draft interpretive guidelines ▶ Review and comment from ROs/States/Professional/Advocates/Industry • Clearance draft interpretive guidelines ▶ Final interpretive guidelines	Completed Completed 11/30/98 12/31/98	CMSO (Sam Kidder) 410-786-6795 Partner: OCSQ; OCOS, RO	Draft instructions developed & sent to ROs, States, advocates & providers on 8/28/98 for review & comment, analyzing comments. Staff from CO and States are scheduled to meet on 11/16/98 with the American Medical Directors Assn., AAHSA, AHCA, NCCNHR, ASCP, etc., to go over the differences in the drug criteria.
HCFA-4(a). Add Survey Task to Look at a Provider's Abuse Intervention System ▶ Working draft manual instructions & survey protocol ▶ Review and comment by ROs/States/professionals and advocates/providers • Clearance draft manual instructions & survey protocol ▶ Final manual instructions & survey protocol	1/31/99 2/29/99 3/31/99 4/30/99	CMSO (Cindy Graunke) 410-786-6782 Partners: OCOS, RO	Abuse forum held 9/29/98; next meeting in December. Workgroups identified including nursing home survey task and education campaign. Draft survey protocol in review by internal workgroups in preparation for December meeting.
HCFA-4(b). Abuse Intervention Campaign ▶ Letter & List of proposed participants to invite ▶ Meeting with abuse forum representatives • Develop key promotional themes & plans ▶ Get feedback on plan from partners ▶ Focus test messages; Campaign begins • Print & distribute messages to targeted audiences	Completed Completed 11/30/98 12/31/98 1/31/99 2/29/99	CBS (Michael McMullan) 410-786-4280 Partners: CMSO/DEHPG/DOI; OCSQ; RO; OCOS; DHHS	Workgroup members designated. Conducting inventory of existing abuse materials from States for key message development.
HCFA-5. Prosecution of Egregious Violations ▶ Preliminary discussions with DOJ and IG ▶ Conference with DOJ and OIG to develop interagency plan	Completed Completed	CMSO (Cindy Graunke) 410-786-6782 Partners: DOJ, OIG, RO, OCOS	Conference with OIG & DOJ held 10/21/98-10/22/98. HCFA participated in teleconference with DoJ on 10/30/98. A second teleconference with DoJ was held on 11/6/98.

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NURSING HOME IMPLEMENTATION SCHEDULE

Project	Completion Dates	Lead (in bold)	Status
HCFA-6. Survey Results on Internet ▶ Determine data fields to be included on Internet ▶ Contractor programs system ▶ Focus groups to determine effectiveness ▶ Survey results on Internet - Testing Phase ▶ Roll-out	Completed Completed Completed Completed 12/31/98	CBS (Michael McMullan) 410-786-4280 Partners: CMSO/ DEHPG/DOI; CMSO/DSG	Internet site up on 9/30/98.
HCFA-7(a). Criminal Background Checks ▶ Draft legislation	Completed	OL (Don Johnson) 202-690-7762 Partners: CMSO; OCSQ; state govts; providers; FBI; advocates; RO	Legislation submitted to Congress 7/29/98. Other legislation (P.L. 105-277 Section 124), which was passed, establishes permissive structure supporting checks.
HCFA-7(b). National Registry to Incorporate State Registries ▶ Draft legislation	Completed	OL (Don Johnson) 202-690-7762 Partners: CMSO; OCSQ; state govt.; providers; FBI; advocates; RO	Legislation submitted to Congress 7/29/98.
HCFA-7(c). Increase Staff Feeding Residents ▶ Draft legislation	Completed	OL (Don Johnson) 202-690-7762 Partners: RO; CMSO; OCOS, OCSQ; providers; advocates; health care professionals; ASPE	Legislation submitted to Congress 7/29/98.

**Health Care Financing Administration
Nursing Home Initiative Update #2
November 16, 1998**

HCFA Action on GAO Recommendations:

- GAO-1. Stagger or otherwise vary the scheduling of standard surveys to effectively reduce the predictability of surveyor visits.**

Status:

We have drafted a manual instruction which includes guidance to States to begin some of their surveys on evenings and weekends, to vary the sequencing of surveys in a geographical area to avoid alerting others that the surveyors are in the area, and to vary the month in which surveys are conducted for a specific survey. The draft manual instruction was sent to regional offices, States, providers and advocates for their review and comment. We are in the process of analyzing comments received.

- GAO-2. Review Federal survey procedures to instruct surveyors to take stratified random samples of resident cases and review sufficient numbers and types of resident cases so that surveyors can better detect problems and assess their prevalence.**

Status:

We discussed plans to pilot test the revised survey process with stakeholder groups (listed below) on 8/17; 8/19 and 8/21. The revised survey process will be piloted in April 1999 using quality indicators for nutrition/hydration and pressure sores. A contract was let on 9/22/98 for developing these quality indicators in the survey process. A teleconference was held on 11/4/98 with the contractor to begin planning the April 1999 changes, and a meeting is scheduled for 11/17/98-11/18/98 for contract kickoff and presentation of contractor's system. Internal HCFA meeting held on 11/5/98 to plan next steps to generate better surveyor guidance in nutrition, hydration, and pressure sore areas.

- GAO-3. Eliminate the grace period for homes cited for repeated serious violations and impose sanctions promptly, as permitted under existing regulations.**

Status:

A memo was released on 9/25/98 phasing in elimination of the opportunity for facilities with poor compliance histories to correct their deficiencies before remedies are imposed.

- GAO-4. Require that for problem homes with recurring serious violations, State surveyors substantiate, by means of an on-site review, every report to HCFA of a home's resumed compliance status.**

Status:

Completed. A memo to Regional Offices and States was sent on August 20, 1998. In addition, copies were sent to provider and consumer advocates.

HCFA Action on Presidential Initiatives:

HCFA-1. Stronger Enforcement Actions

- HCFA-1(a) • Revise definition of "Poor Performer"

Status:

We discussed a revised definition of "poor performer" facility with stakeholder groups on 8/17; 8/19; and 8/21. We issued a memo on 9/25/98 to the Regional Offices phasing in the definition of poor performer.

- HCFA-1(b) • Permit States to impose civil money penalties for "each instance".

Status:

We have requested that a final regulation with comment be included on HCFA's Regulatory Schedule, with the regulation to be published in December 1998. The draft regulation was sent to HCFA's Regulations Staff on 9/18/98. The regulations team met on 11/2, 11/4 and 11/10 to discuss team comments. Team revisions have been incorporated and will be returned to the Regulations Staff the week of 11/16/98.

- HCFA-1(c) • Inspect certain nursing homes more frequently without decreasing inspection frequency for other facilities.

Status:

We have developed criteria to identify 100 facilities nationwide which require more intense monitoring. Criteria and names of specific facilities were solicited from stakeholder groups on 8/17; 8/19 and 8/21. We are in the process of working with States to refine the methodology for selecting the homes and finalizing the list.

- HCFA-1(d) • Stagger nursing home inspections.

Status:

Same as GAO-1 above.

- HCFA-1(e) • Federal and State officials will focus their enforcement efforts on nursing homes within chains that have a record of noncompliance with Federal rules.

Status:

We solicited ideas from stakeholder groups on 8/17; 8/19 and 8/21 for criteria which would trigger a nursing home chain to be considered a "poor performer". A guideline memo was issued on 9/25/98 that recommends a State agency course of action--If a facility is found to have

deficiencies during the survey, and the State is aware that another facility(ies) within the same chain has been designated as a "poor performing" facility, HCFA recommends that the facility being surveyed also be assigned the "poor performing" designation. This means that the surveyed chain facility would NOT be given an opportunity to correct deficiencies prior to the imposition of remedies. Proposed criteria and preliminary review of OSCAR data has been completed. An overall strategy plan has been forwarded to the ROs for comment.

HCFA-2. Stronger Federal Oversight

- HCFA-2 (a)•** Provide additional training and other assistance to inspectors in States that are not adequately protecting residents; terminate funding to States that fail to adequately perform survey functions or fail to improve inadequate survey systems.

Status:

We solicited ideas from stakeholder groups on 8/17; 8/19; and 8/21 for criteria which would trigger a Federal response to inadequate survey performance. A workgroup of Central Office and Regional Office members has been created to develop these criteria for review and comment by stakeholder groups by 1/31/99.

- HCFA-2(b)•** Enhance Federal review of surveys conducted by States. Standard evaluation protocols will be implemented in every State this fall.

Status:

A new Federal Monitoring System (FMS) has been developed. The protocols have been piloted and full implementation began on 9/30/98.

HCFA-3. Preventing Bed Sores, Dehydration and Malnutrition

- HCFA-3(a)•** Repository of best practices guidelines for care for residents at risk of weight loss and dehydration.

Status:

We have solicited and received practice guidelines and protocols to be reviewed and included in this national repository. Awaiting inclusion on HCFA's website.

- HCFA-3(b)•** National campaign to increase awareness on the prevention of malnutrition and dehydration.

Status:

We have established a workgroup to plan a national nutrition campaign. The first teleconference was conducted on September 21, 1998. The Denver Regional Office is conducting weekly conference calls and environmental scanning of existing/local materials in States for key message development.

- HCFA-3©•** Clearer guidance on key quality of life/quality of care issues (including nutrition and hydration concerns and admissions contracts for newly admitted residents).

Status:

We are developing a survey protocol using quality indicators for both nutrition, hydration and pressure sores (see also GAO-2 above).

- HCFA-3(d)** Using Effective Drugs

Status:

Draft manual instructions were sent to stakeholders for review and comment. We are in the process of completing our analysis of the comments received.

HCFA-4. Combating Resident Abuse

- HCFA-4(a)•** Add survey task to look at a provider's abuse intervention system.

Status:

A Stakeholder meeting was held on September 29 to review our survey task for reviewing a nursing home's abuse intervention system. New survey task and interpretive guideline changes have been formulated in first draft by CO/RO team.

- HCFA-4(b)•** Abuse Intervention Campaign

Status:

The workgroup for the national abuse prevention campaign has been created. The Philadelphia RO is conducting conference calls and environmental scanning for existing/local materials for key message development.

HCFA-5. Prosecution of Egregious Violations

Status:

HCFA participated in a joint conference with OIG and the Department of Justice • October 21-22. The purpose of this conference is to find better ways to communicate and refer questionable cases to either the OIG or DoJ. Karen Morrisette, representing DoJ's Criminal Division, met with HCFA staff on 11/13/98 for an initial discussion of the current HCFA/DoJ Memorandum of Understanding and to discuss various options and time frames for HCFA training for law enforcement officials.

HCFA-6. Publishing Survey Results on the Internet

Status:

We have developed a working internet site and conducted 2 focus groups with area senior citizen centers to test its usefulness to the public. Comments were also solicited from the stakeholder meetings held 8/17; 8/19; and 8/21. The Internet site went up live in a testing phase on September 30, 1998.

HCFA-7. Legislative Activity

HCFA-7(a)• Criminal Background Checks

Status:

Legislative language submitted to Congress on 7/29/98

HCFA-7(b)• National Registry to Incorporate State Registries

Status:

Legislative language submitted to Congress on 7/29/98

HCFA-7(c)• Increase Staff Feeding Residents

Status:

Legislative language submitted to Congress on 7/29/98

Meetings Held with Outside Groups:

October 18 American Dietetic Association (ADA)

In attendance at this meeting was the President of the ADA and several members of the Consultant Dietitians in Health Care Facilities practice group.

The purpose of the meeting was to discuss ADA's partnership with HCFA and to obtain HCFA's comments on a set of draft recommendations to address the President's nursing home initiative. ADA will send a formal letter describing the partnership with HCFA to the Administrator. The group discussed its desire to serve as a resource to HCFA in sharing information and providing technical support in the development of practice/care guidelines and training curricula.

October 20 Nursing Home Advocates

Nursing home advocate groups including: National Citizens' Coalition for Nursing Home Reform, American Association of Retired Persons, National Senior Citizens Law Center, National Committee to Preserve Medicare and Social Security, and National Association of State Ombudsman Programs.

The purpose of the meeting was to continue an ongoing dialog with the advocate community. The latest nursing home implementation report was distributed and discussed. There was discussion regarding nursing home staffing and HCFA's

contract with Abt Associates to study the issue. NCCNHR also presented a eight-page set of comments regarding the President's initiatives.

- October 20 **Region and State Dietitians Working in Medicare/Medicaid**
The State dietitian surveyors meet annually with HCFA regional and CO dietitians in conjunction with the national meeting of the ADA. The purpose of the meeting is to share information, improve survey skills in the application and interpretation of Federal regulations, and to provide peer review of dietary practices. Of great interest this year was HCFA's approach to the President's nursing home initiative. Dietitians expressed concern with the decreasing number of dietitians being employed in the States and regional offices to address malnutrition, weight loss, dehydration, and pressure ulcers in nursing homes. It is worth noting that unless a resident is well nourished, all other therapies are wasted because the quality of care and life sought will be illusive. Also in attendance at this meeting were members from ADA's leadership.
- Oct 21-22 **Department of Justice/Office of Inspector General/HCFA Conference**
The purpose of this conference is to find better ways to communicate and refer questionable cases to either the OIG or DoJ. Representatives from the Veterans Administration, FBI, District Attorneys, States' Attorneys, Medicaid Fraud Units were also in attendance. The next steps is to develop a joint plan which includes both training and altering the Memorandum of Understanding.
- October 26 **Association of Health Facility Survey Agencies Conference**
State survey agency personnel, HCFA staff and selected speakers.

HCFA provided both a Keynote address and a 1 ½ hour plenary session on the nursing home initiative. Issues raised included funding of the nursing home initiative as well as asking for clarifications on HCFA policies.
- Nov 2-3 **American Association of Homes and Services for the Aging Conference**
Nursing home providers, Assisted Living providers, Continuing Care Retirement Community providers, Trustees, Board Members, and selected speakers. •

HCFA was represented on the issues of prospective payment and the nursing home initiative during a session on Health Policy Forum. Providers expressed concern over HCFA's internet site because they believe it could make nursing homes sound worse than they were, the consistency of citation of deficiencies among States, and the definition of "poor performer" which they believe will capture too many nursing homes. On November 3, HCFA staff met with 10 State representatives from the Association to discuss how HCFA and AAHSA can work together. AAHSA State representatives were encouraged to send HCFA good examples of how nursing homes are working.

November 4 **Nutrition Screen Initiative (NSI)**

The NSI is a coalition of health care organizations that advise on nutrition for older Americans. Its Advisory Board consists of the ADA, American Association of Homes and Services for the Aging, American Academy of Family Physicians, American Geriatrics Society, American Health Care Association, American Medical Directors Association, American Society of Consultant Pharmacists, Case Management Society of America, National Association of Directors of Nursing in Long Term Care, National Citizens' Coalition for Nursing Home Reform, National Council on the Aging, and National Gerontological Nurses Association.

The purpose of the meeting was to discuss HCFA's approach to the President's nursing home initiative and seek input on a set of proposed checklists/guidelines on malnutrition, weight loss, dehydration, and pressure ulcers focused toward and general public and others as appropriate. The draft checklists/guidelines will be available in early 1999.

Nov 7-10 **National Citizens Coalition for Nursing Home Reform Conference**

Nursing home advocates, nursing home residents, HCFA staff, and selected speakers.

HCFA participated as a "listener" on Saturday, November 7; staff presented during the conference on the nursing home staffing study and the minimum data set. Administrator DeParle attended the conference to listen and participate in a panel for three hours on November 10. There were also several HCFA staff in attendance during the conference.

Meetings Scheduled:

November 19 Meeting with NCCNHR

Early Dec. Meeting with Abuse Stakeholders group.

DRAFT*: Nursing Home Quality Of Care Action Plan

HCFA/DOJ: NURSING HOME QUALITY OF CARE ACTION PLAN COMPARISON					
DOJ: 22 Points	DOJ Action Plan Point Description	Primary Responsibility: DOJ or HCFA	Presidential Initiative	DOJ Proposed Timeline	HCFA Proposed Date
1	Form headquarters level Nursing Home Work Group to draft and implement plan	DOJ	5	November 10, 1998 (draft only) December 15, 1998	January 15, 1999
2	Form local, state, or regional level multi-agency Nursing Home Task Forces to undertake Nursing Home Enforcement Initiative	DOJ (Criminal, Civil, AGAC Subcommittee)	5	January - March 1999	March 15, 1999
3	Design Nursing Home Quality of Care Training Conference for regional distribution to multi- agency audiences	DOJ (OLE, HCFA, OIG)	5	January - March 1999	April 15, 1999
4	Integrate VA into the Nursing Home Enforcement Process	DOJ	1(c), 5	January 1999	June 15, 1999
5	Renegotiate the CMP MOU between HCFA and DOJ	Nursing Home Work Group (Headquarters)	1(b), 5	January 1999	March 15, 1999
6	Determine current handling of CMP referrals	DOJ (AGAC Subcommittee)	1(b), 5	December 1, 1998	January 15, 1999
7	Devise a method for searching data (including surveys, MDS, OSCAR) on the basis of chain affiliation of facilities	HCFA	1(c)	January 1999	***Y2K Dependent

8	Design and implement changes in databases to ensure that data on nursing home encounters is useful for enforcement purposes (including statistical reporting)	HCFA	n/a	March 1999	***Y2K Dependent
9a	Make and implement recommendations concerning changes in attestations and certifications associated with payment and submission of data concerning nursing home and related services	HCFA	n/a *Note: This is covered in the DOJ systematic weakness report	January 1999	***Y2K Dependent
9b	Make and implement narrowly tailored recommendations for changes in the regulations to establish clearer and more specific quality of care standards	HCFA, OGC, DOJ (Civil)	3 (a),(b),(c),(d)	December 1999	April 2000
10	Conduct outreach to industry, beneficiary, advocacy, ombudsmen, and nursing home employee and service groups	Nursing Home Work Group (National); District Level (Local)	6	January - March 1999	May 1999
11	Review patient abuse and neglect legislation (state law) for possible model state legislation	DOJ (OJP/OVC/and Civil Rights)	n/a	6 months survey 6 months law	n/a
12	Make recommendations concerning possible new legislation (for example, civil penalty provision for pattern of abuse/neglect and injunctive relief)	DOJ (ODAG)	7(a),(b),(c)	December 1998	n/a

13	Review current services available to victims of abuse and neglect to determine whether changes in statutory, regulatory, or other provision are necessary to improve services	DOJ (Civil Rights and OJP/OVC)	4(b)	March 1999	March 1999
14	Amend HCFA beneficiary incentive database to flag and refer quality of care allegations	HCFA-OFM-PIG	n/a	Immediate	Completed
15	Review referral protocol for OIG hotline complaints to determine handling of nursing home quality of care allegations	OIG	n/a	Immediate	n/a
16	Amend training materials/state survey agency contracts/manuals/ state operations manual regarding referrals to law enforcement	HCFA	2(a)	after #2 and #5	April 1999
17	Prepare materials to be distributed to ombudsmen, surveyors, and patient advocates concerning federal and state nursing home enforcement agencies and contacts	DOJ (Civil Rights)	6	March 1999	March 1999
18	Identify emerging quality of care and fraud problems associated with nursing home, home health, and congregate living situations as a result of the changes in payment methodologies	HCFA (Headquarters)	n/a	January 1999	Ongoing

19	Place Nursing Home Quality of Care and Fraud issues on schedule for HHS OIG industry guidance	OIG	n/a	1999	n/a
20	Amend DOJ guidance on Quality of Care referrals to emphasize referrals to state and local law enforcement (after consultation with NDAA)	DOJ (Civil Division)	n/a	November 15, 1998	n/a
21	Draft and distribute guidance for investigators and prosecutors regarding need to provide feedback to sources of referral concerning action/status	DOJ (Civil Division)	n/a	December 1, 1998	n/a
22	Draft and distribute guidance to task forces concerning need for early involvement of the OIG in nursing home matters to ensure viability of exclusion remedy	OIG	n/a	December 1, 1998	na/

*Negotiations at the staff level are ongoing

ASTHMA - Dr says
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