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GAO

Report to Congressional Requesters

May 2008

NURSING HOMES

Federal Monitoring Surveys Demonstrate Continued Understatement of Serious Care Problems and CMS Oversight Weaknesses

GAO-08-517

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GAO Accountability • Integrity • Reliability

Highlights

Highlights of GAO-08-517, a report to congressional requesters

Why GAO Did This Study

GAO reports since 1998 have demonstrated that state surveyors, who evaluate the quality of nursing home care on behalf of CMS, sometimes understate the extent of serious care problems in homes because they miss deficiencies. CMS oversees the effectiveness of state surveys through the federal monitoring survey program. In this program, federal surveyors in CMS's regional offices either independently evaluate state surveys by resurveying a home (comparative surveys) or directly observe state surveyors during a routine nursing home survey (observational surveys). GAO was asked to evaluate the information federal monitoring surveys provide on understatement and the effectiveness of CMS management and oversight of the survey program. To do this, GAO analyzed the results of federal monitoring surveys for fiscal years 2002 through 2007, reviewed CMS guidance for the survey program, and interviewed headquarters and regional office officials.

What GAO Recommends

GAO is making four recommendations to the CMS Administrator to address weaknesses in CMS's management of the federal monitoring survey database that affect the agency's ability to track understatement and CMS's ability to oversee regional office implementation of the federal monitoring survey program. In its comments on a draft of this report, HHS fully endorsed and indicated it would implement GAO's recommendations.

To view the full product, including the scope and methodology, click on GAO-08-517. For more information, contact John E. Dicken at (202) 512-7114 or dickenj@gao.gov.

What GAO Found

A substantial proportion of federal comparative surveys identify missed deficiencies at the potential for more than minimal harm level or above. During fiscal years 2002 through 2007, about 15 percent of federal comparative surveys nationwide identified state surveys that failed to cite at least one deficiency at the most serious levels of noncompliance—actual harm and immediate jeopardy. Overall, nine states missed serious deficiencies on 25 percent or more of comparative surveys; in seven states federal surveyors identified no such missed deficiencies. During the same period, missed deficiencies at the lowest level of noncompliance—the potential for more than minimal harm—were more widespread: nationwide, approximately 70 percent of federal comparative surveys identified state surveys missing at least one deficiency at the lowest level of noncompliance, and in all but five states the number of state surveys with such missed deficiencies was greater than 40 percent. Undetected care problems at this level are a concern because they could become more serious if nursing homes are not required to take corrective action. The most frequently missed type of deficiency on comparative surveys, at the potential for more than minimal harm level and above, was poor quality of care, such as ensuring proper nutrition and hydration and preventing pressure sores. Federal observational surveys highlighted two factors that may contribute to understatement of deficiencies: weaknesses in state surveyors' (1) investigative skills and (2) ability to integrate and analyze information collected to make an appropriate deficiency determination. These factors may contribute to understatement because they directly affect the appropriate identification and citation of deficiencies.

CMS has taken steps to improve the federal monitoring survey program, but weaknesses remain in program management and oversight. For example, CMS has improved processes to ensure that comparative surveys more accurately reflect conditions at the time of the state survey, such as requiring that comparative surveys occur within 30 working days of the state survey rather than within the 2 months set in statute. Despite these improvements, the management and oversight potential of the program has not been fully realized. For example, CMS has only begun to explore options for identifying understatement that occurs in cases where state surveys cite deficiencies at too low a level, for possible implementation in fiscal year 2009. In addition, CMS is not effectively managing the federal monitoring survey database to ensure that the regional offices are entering data accurately and reliably—CMS was unaware, for example, that a considerable number of comparative surveys had not been entered. Furthermore, CMS is not using the database to oversee consistent implementation of the program by the regional offices—for example, the agency is not using the database to identify inconsistencies between comparative and observational survey results.

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Abbreviations

CMS	Centers for Medicare & Medicaid Services
HHS	Department of Health & Human Services
OSCAR	On-Line Survey, Certification, and Reporting system

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Accountability * Integrity * Reliability

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Washington, DC 20548

May 9, 2008

The Honorable Herb Kohl
Chairman
Special Committee on Aging
United States Senate

The Honorable Charles E. Grassley
Ranking Member
Committee on Finance
United States Senate

Since 1998, Congress has focused considerable attention on the need to improve the quality of care for the nation's 1.5 million nursing home residents, a highly vulnerable population of elderly and disabled individuals for whom remaining at home is no longer feasible. Poor quality of care—worsening pressure sores or untreated weight loss—in a small but unacceptably high number of nursing homes continues to harm residents or place them in immediate jeopardy, that is, at risk of death or serious injury. About 1 in 5 homes nationwide were cited for such serious deficiencies on state inspections, known as surveys, in fiscal year 2007 (see app. I). Our previous work, however, demonstrated that state surveys sometimes understated the extent of serious care problems and that federal oversight of state survey activities had weaknesses.[1] Understatement can occur when a state surveyor fails to cite a deficiency altogether or cites a deficiency at too low a level.

[1]See GAO, *California Nursing Homes: Care Problems Persist Despite Federal and State Oversight*, GAO/HEHS-98-202 (Washington, D.C.: July 27, 1998); *Nursing Home Care: Enhanced HCFA Oversight of State Programs Would Better Ensure Quality*, GAO/HEHS-00-06 (Washington, D.C.: Nov. 4, 1999); and *Nursing Home Quality: Prevalence of Serious Problems, While Declining, Reinforces Importance of Enhanced Oversight*, GAO-03-561 (Washington, D.C.: July 15, 2003). A list of related GAO products is at the end of this report.

The Centers for Medicare & Medicaid Services (CMS) is the federal agency responsible for ensuring the effectiveness of state surveys.[2] Through CMS's federal monitoring survey program, federal surveyors either (1) independently evaluate state surveys by resurveying a home recently inspected by state surveyors and comparing the deficiencies identified during the two surveys, known as a comparative survey, or (2) directly observe state surveyors during a routine nursing home survey, known as an observational survey. Results from both federal comparative and observational surveys—which are recorded in the federal monitoring survey database—allow CMS to gauge states' abilities to accurately assess nursing home quality.

Recently, we reported that federal comparative surveys in five large states identified the continuing understatement of serious care problems by state surveyors.[3] You asked us to look at the understatement of serious deficiencies by state surveyors nationwide. In this report we address two questions: (1) what information do federal monitoring surveys provide about understatement nationwide, and (2) how effective are CMS management and oversight of the federal monitoring survey program?

To answer the first question, we analyzed the results of comparative and observational surveys nationwide for fiscal years 2002 through 2007 using the federal monitoring survey database.[4] During this period, federal surveyors conducted 976 comparative surveys and 4,023 observational

[2]All homes that participate in the Medicare and Medicaid programs are subject to periodic surveys to ensure that they are in compliance with federal quality standards. CMS contracts with state survey agencies to conduct the surveys. Medicare, the federal health care program for elderly and disabled individuals, covers up to 100 days of skilled nursing home care following a hospital stay. Medicaid, the joint federal-state health care financing program for certain categories of low-income individuals, pays for the nursing home care of qualifying individuals who can no longer live at home. Combined Medicare and Medicaid payments for nursing home services were about $75 billion in 2006, including a federal share of about $51 billion.

[3]See GAO, *Despite Increased Oversight, Challenges Remain in Ensuring High-Quality Care and Resident Safety*, GAO-06-117 (Washington, D.C.: Dec. 28, 2005); and *Nursing Home Reform: Continued Attention Is Needed to Improve Quality of Care in Small but Significant Share of Homes*, GAO-07-794T (Washington, D.C.: May 2, 2007). In both reports, we examined understatement for five states—California, Florida, New York, Ohio, and Texas. Results from the May 2007 report showed that understatement of serious deficiencies varied across these states from a low of 4 percent in Ohio to a high of 26 percent in New York during the 5-year period March 2002 through March 2007.

[4]Fiscal year 2002 was the first year that the database contained all the information needed to assess the results of federal comparative surveys.

surveys. To identify understatement on comparative surveys, we focused our analysis on cases where federal surveyors determined that state surveyors should have cited a deficiency but failed to do so or where state surveyors cited a deficiency at too low a level. We analyzed the results of observational surveys in order to better understand why understatement might occur. Deficiencies identified during nursing home surveys are categorized according to their scope (i.e., the number of residents potentially or actually affected) and severity (i.e., the degree of relative harm involved). Homes with deficiencies at the A though C levels are considered to be in substantial compliance, while those with deficiencies at the D through L levels are considered out of compliance. (See table 1.) Throughout this report, we refer to deficiencies at the actual harm and immediate jeopardy levels as serious deficiencies.

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

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

Source: CMS.

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

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

To ensure reliability of the federal monitoring survey database, we discussed data entry procedures with all 10 CMS regional offices, whose staff enter information into the database. In addition, we conducted several data reliability tests, including (1) automated checks of data fields to ensure that they contained complete information and (2) manual reviews of a random sample of all deficiencies cited by federal but not state surveyors to ensure that federal surveyors had used the data fields appropriately. We also eliminated a small number of deficiencies that did not correspond to a defined severity level or contained illogical survey dates—such as a comparative survey that began prior to the state survey. Based on these activities, we determined that the information was sufficiently reliable for our purposes. Data on comparative surveys, however, cannot be used to project the extent of understatement across all state surveys because the state surveys selected for federal monitoring

surveys are not representative of all nursing home surveys or survey teams within each state.

To answer the second question, we reviewed CMS guidance for the federal monitoring survey program and interviewed officials in CMS headquarters and all 10 regional offices. Our work focused on CMS's (1) efforts to improve the use of comparative surveys as an oversight tool; (2) ability to track the understatement of deficiencies; and (3) management of the federal monitoring survey database, including the use of the database to oversee regional office implementation of the federal monitoring survey program. We also analyzed (1) the comments entered into the federal monitoring survey database by federal surveyors for certain discrepancies between federal and state survey findings and (2) the consistency between comparative and observational survey results within states and CMS regional offices. We performed our work from July 2007 through May 2008 in accordance with generally accepted government auditing standards.

Results in Brief

A substantial proportion of federal comparative surveys identify missed deficiencies at the potential for more than minimal harm level or above. From fiscal year 2002 through 2007, about 15 percent of federal comparative surveys nationwide identified state surveys that failed to cite at least one deficiency at the most serious levels of noncompliance—the actual harm and immediate jeopardy levels. Overall, in nine states federal surveyors identified missed serious deficiencies on 25 percent or more of comparative surveys, but in seven states they identified no missed serious deficiencies. During the same period, missed deficiencies at the potential for more than minimal harm level were more widespread: nationwide, approximately 70 percent of federal comparative surveys identified state surveys missing at least one deficiency at the potential for more than minimal harm level, and in all but five states the number of state surveys with such missed deficiencies was greater than 40 percent. Such undetected care problems are of concern because they could become more serious over time if nursing homes are not required to take corrective actions. The most frequently missed deficiencies identified on comparative surveys—from the potential for more than minimal harm through immediate jeopardy levels—involved poor quality of care, such as ensuring proper nutrition and hydration and preventing pressure sores. Federal observational surveys highlighted two factors that may contribute to the understatement of deficiencies—weaknesses in state surveyors' investigative skills and in their ability to integrate and analyze the information collected to make an appropriate deficiency determination. Six of the nine states that missed serious deficiencies on 25 percent or

more of comparative surveys had observational survey ratings for these two dimensions that were worse than the national average.

CMS has taken steps to improve the federal monitoring survey program, but weaknesses remain in program management and oversight. For example, CMS has improved processes to ensure that comparative surveys more accurately reflect conditions at the time of the state survey, such as requiring that comparative surveys occur within 30 working days of the state survey rather than within the 2 months set in statute. However, despite these improvements, the management and oversight potential of the program has not been fully realized. First, we found that the federal monitoring survey database did not capture the full extent of understatement because CMS does not require regional offices to determine when state surveyors cite a deficiency at too low a level. The agency has only begun exploring options for identifying potential scope and severity understatement. When we manually analyzed optional comment fields in the database to assess how often a deficiency was cited at too low a level, we were able to confirm this type of understatement in 38 percent of the cases we examined; when combined with understatement caused by missed deficiencies, overall understatement of serious deficiencies by state surveyors increased from about 15 percent to about 16 percent for fiscal years 2002 through 2007. Second, we found that CMS was not effectively managing the database to ensure that the regional offices were entering data accurately and reliably. CMS was unaware, for example, that a considerable number of comparative surveys had not been entered. Finally, we found weaknesses in CMS's use of the database for regional office oversight. For example, despite the fact that inconsistencies in comparative and observational survey findings in specific states could indicate that some CMS regional offices did not follow CMS guidance in assessing state surveyor performance, CMS officials told us that they did not plan to follow up with regional offices about these inconsistencies.

We are making four recommendations to the CMS Administrator to address weaknesses in CMS's management and oversight of federal monitoring surveys. We recommend that CMS (1) require regional offices to determine if there was understatement when state surveyors cite a deficiency at a lower scope and severity level than federal surveyors and to track this information, (2) establish quality controls to improve the accuracy and reliability of information entered into the federal monitoring survey database, (3) routinely examine comparative survey data and hold regional offices accountable for implementing CMS guidance that is intended to ensure that comparative surveys more accurately capture the

conditions at the time of the state survey, and (4) regularly analyze and compare federal comparative and observational survey results. We provided a draft of this report to CMS through the Department of Health & Human Services (HHS). The comments we received were submitted by HHS. HHS fully endorsed and indicated it would implement our recommendations.

Background

Oversight of nursing homes is a shared federal-state responsibility. Based on statutory requirements, CMS (1) defines quality standards that nursing homes must meet to participate in the Medicare and Medicaid programs and (2) contracts with state survey agencies to assess whether homes meet those standards through annual surveys and complaint investigations.[5] Although CMS has issued extensive guidance to states on determining compliance with federal quality requirements, we have found that some state surveys understate quality problems at nursing homes.[6]

Federal Quality Standards

Federal nursing home quality standards focus on the delivery of care, resident outcomes, and facility conditions. These standards, totaling approximately 200, are grouped into 15 categories, such as Resident Rights, Quality of Life, Resident Assessment, Quality of Care, Pharmacy

[5]In addition to nursing homes, CMS and state survey agencies are responsible for oversight of other Medicare and Medicaid providers, such as home health agencies, intermediate care facilities for the mentally retarded, and hospitals.

[6]Several GAO reports have documented understatement of serious deficiencies by state surveyors. For one report, in 1998, we arranged for a team of registered nurses to accompany state surveyors and conduct concurrent surveys designed specifically to identify quality-of-care problems. The survey methodology we used differed from the methodology used by state surveyors in that it was more rigorous and reviewed a larger sample of cases. Using this methodology, our surveys spotted 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. (See GAO/HEHS-98-202.) In addition, we have documented considerable interstate variation in the proportion of homes cited for serious care problems. For example, 8 percent of Florida's 683 homes and 38 percent of Connecticut's 244 homes were cited for serious care problems in fiscal year 2007. The extent of this variation suggests inconsistency in how states conduct surveys and understatement of serious quality problems. App. I shows the proportion of homes in each state cited by state surveyors for serious deficiencies from fiscal year 2002 through 2007.

Services, and Administration.[7] For example, there are 23 standards within the Quality of Care category ranging from "promote the prevention of pressure [sore] development" to "the resident environment remains as free of accident hazards as is possible." CMS has also developed detailed investigative protocols to assist state survey agencies in determining whether nursing homes are in compliance with federal quality standards. This guidance is intended to ensure the thoroughness and consistency of state surveys and complaint investigations.

Standard Surveys and Complaint Investigations

Every nursing home receiving Medicare or Medicaid payment must undergo a standard state survey not less than once every 15 months, and the statewide average interval for these surveys must not exceed 12 months. During a standard survey, teams of state surveyors—generally consisting of registered nurses, social workers, dieticians, or other specialists—evaluate compliance with federal quality standards. Based on the care provided to a sample of residents, the survey team (1) determines whether the care and services provided meet the assessed needs of the residents and (2) measures resident outcomes, such as the incidence of preventable pressure sores, weight loss, and accidents. In contrast to a standard survey, a complaint investigation generally focuses on a specific allegation regarding a resident's care or safety and provides an opportunity for state surveyors to intervene promptly if problems arise between standard surveys. Surveyors generally follow state procedures when investigating complaints, but must comply with certain federal guidelines and time frames.

Enforcement

When deficiencies are identified, federal sanctions can be imposed to help encourage homes to correct them. Sanctions are generally reserved for serious deficiencies—those at the G through L levels—which constitute actual harm and immediate jeopardy.[8] Sanctions for such serious quality problems can affect a home's revenues and provide financial incentives to

[7]Other areas include Admission, Transfer and Discharge Rights; Resident Behavior and Facility Practices; Nursing Services; Dietary Services; Physician Services; Specialized Rehabilitative Services; Dental Services; Infection Control; and Physical Environment. Surveys also examine compliance with federal fire safety requirements.

[8]The scope and severity of a deficiency is one of four factors that CMS takes into account when imposing sanctions. CMS also considers a home's prior compliance history, desired corrective action and long-term compliance, and the number and severity of all the home's deficiencies.

return to and maintain compliance. Such sanctions include fines known as civil money penalties, denial of payment for new Medicare or Medicaid admissions, or termination from the Medicare and Medicaid programs.

State surveys that miss serious deficiencies or cite deficiencies at too low a scope and severity level have enforcement implications because a nursing home may escape sanctions intended to discourage repeated noncompliance. For example, facilities that receive at least one G through L level deficiency on successive standard surveys or complaint investigations must be referred for immediate sanctions.[9] In addition, CMS guidance calls for higher fines when a home has a poor compliance history and requires that state survey teams revisit a home to verify that serious deficiencies have actually been corrected (such revisits are not required for most deficiencies cited below the actual harm level—A through F).[10]

CMS Oversight of State Surveys

Statutorily required federal monitoring surveys, which are conducted annually in at least 5 percent of state-surveyed Medicare and Medicaid nursing homes in each state, are a key CMS oversight tool in ensuring the adequacy of state surveys.[11] CMS headquarters—specifically, CMS's Survey and Certification Group—is responsible for the management of the federal monitoring survey database and for oversight of the 10 CMS regional offices' implementation of the federal monitoring survey program.[12] Federal surveyors located in regional offices conduct federal monitoring surveys. The surveys can be either comparative or observational, with each offering unique advantages and disadvantages as an oversight tool. For example, an advantage of comparative surveys is that they are an independent evaluation of a nursing home recently surveyed by a state

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

[10]A revisit is required for F level deficiencies that are cited in one of three areas: Quality of Care, which can include deficiencies such as inadequate treatment or prevention of pressure sores; Quality of Life, which can include deficiencies such as a failure to accommodate the needs and preferences of residents; and Resident Behavior and Facility Practices, which can include deficiencies such as a failure to protect residents from abuse.

[11]In addition, CMS also conducts annual state performance reviews, which include an examination of the quality of state survey agency investigations and decision making and the timeliness and quality of complaint investigations.

[12]Throughout this report, when we refer to CMS headquarters or CMS headquarters officials, we mean the Survey and Certification Group and its officials.

survey agency team. A disadvantage is that the time lag between the two surveys can make analysis of differences difficult.

- **Comparative survey**. A federal survey team conducts an independent survey of a home recently surveyed by a state survey agency in order to compare and contrast the findings. This comparison takes place after completion of the federal survey. When federal surveyors identify a deficiency not cited by state surveyors, they assess whether the deficiency existed at the time of the state survey and should have been cited by entering either yes or no to the question, "Based on the evidence available to the [state], should the [state survey] team have cited this [deficiency]?" This assessment is critical in determining whether understatement occurred because some deficiencies cited by federal surveyors may not have existed at the time of the state survey. For example, a deficiency identified during a federal survey could involve a resident who was not in the nursing home at the time of the earlier state survey. By statute, comparative surveys must be conducted within 2 months of the completion of the state survey. However, differences in timing, resident sample selection, and staffing can make analysis of differences between the state and federal comparative surveys difficult. On the basis of our prior recommendations, CMS has taken several steps to ensure that comparative surveys more accurately capture conditions at the time of the state survey.[13] For example, CMS now calls for the length of time between the state and federal surveys to be between 10 and 30 working days and requires federal surveyors conducting a comparative survey in a nursing home to include at least half of the state survey's sample of residents from that nursing home in the comparative survey sample, making it easier to determine whether state surveyors missed a deficiency.[14] Furthermore, federal comparative survey teams are expected to mimic the number of staff assigned to the state survey. CMS also issued guidance in October 2002 defining the criteria for federal surveyors to consider when selecting

[13]See GAO/HEHS-00-6.

[14]In December 2001, CMS requested that regional offices conduct comparative surveys between 2 weeks and 1 month after the state survey. In October 2002, CMS relaxed this standard by changing the requirement to between 10 and 30 working days. In general, it is easier for federal surveyors to determine whether state surveyors should have identified deficiencies when conditions during the comparative survey are as close as possible to those existing during the state survey. Reducing the time between state and federal surveys and requiring a review of the quality of care provided to as many of the same nursing home residents as possible enhances the similarities between state and federal surveys.

facilities for comparative surveys.[15] These selection criteria can generally be categorized as state survey team performance and facility characteristics. Regional offices were given latitude in their use of these criteria and may supplement them with other selection factors unique to their regions. For example, some regions use statistics on the prevalence of pressure sores in a nursing home's resident population as a comparative survey selection factor.

- **Observational survey**. Federal surveyors accompany a state survey team to a nursing home to evaluate the team's on-site survey performance and ability to document survey deficiencies. State teams are evaluated in six areas—Concern Identification, Sample Selection, General Investigation, Food-Borne Illness Investigation, Medication Investigations, and Deficiency Determination—and are rated in one of five categories for each of the six measures. The rating categories—from highest to lowest—are extremely effective, very effective, satisfactory, less than satisfactory, and much less than satisfactory. CMS annual state performance reviews require that state survey teams achieve an average rating of satisfactory. Observational surveys allow federal surveyors to provide more immediate feedback to state surveyors and to identify state surveyor training needs. However, observational surveys are not independent evaluations of the state survey. Because state surveyors may perform their survey tasks more attentively than they would if federal surveyors were not present, observational surveys may not provide an accurate picture of state surveyors' typical performance. Since 2001, CMS has also taken steps to strengthen observational surveys. For example, the agency issued written guidance defining a standard process for resolving disagreements and a new manual to increase consistency across observational surveys.

  The 976 federal comparative surveys conducted from fiscal year 2002 through 2007 ranged from as few as 10 in Vermont, which has about 40 facilities, to as many as 49 in California, which has about 1,300 facilities. Of the 4,023 federal observational surveys conducted during the same period, the number ranged from 16 in New Hampshire to 346 in California.

[15]In 1999, we reported that there was little consistency across CMS regional offices in the criteria used to select homes for comparative surveys. For example, some regions were selecting homes that had no serious deficiencies, while others were focusing on homes with serious deficiencies. We noted that federal surveyors were less likely to find missed deficiencies at homes where state surveyors found serious care problems. See GAO/HEHS-00-6.

The results of federal monitoring surveys, including information on the corresponding state surveys, are entered in the federal monitoring survey database. In fiscal year 2002, CMS began including information on comparative surveys in the database, and the agency began requiring federal surveyors to determine whether a deficiency cited by federal but not state surveyors had been missed by determining whether state surveyors should have cited the deficiency.

Understatement of Deficiency Scope and Severity Level

Although comparative surveys and the wide variability across states in the proportion of homes with deficiencies at the actual harm and immediate jeopardy levels indicate that state surveyors miss some serious deficiencies, our prior work has also indicated that state surveyors sometimes understate the scope and severity of a deficiency. In 2003, we found widespread understatement of actual harm deficiencies in a sample of surveys from homes with a history of harming residents.[16] Overall, 39 percent of the 76 state surveys we reviewed had documented problems that should have been classified as actual harm instead of as lower-level deficiencies.

Substantial Proportion of Federal Comparative Surveys Identify Missed Deficiencies

A substantial proportion of federal comparative surveys identify missed deficiencies at the potential for more than minimal harm level or above. From fiscal year 2002 through 2007, about 15 percent of federal comparative surveys nationwide identified state surveys that failed to cite at least one deficiency at the most serious levels of noncompliance—the actual harm and immediate jeopardy levels (G through L). There was wide variation across states in the proportion of comparative surveys that found at least one missed serious deficiency, from more than 25 percent in nine states to none in seven others. In contrast to missed serious deficiencies, missed deficiencies at the potential for more than minimal harm level (D through F) were considerably more widespread, with such missed deficiencies greater than 40 percent in all but five states. Every state had at least one comparative survey with missed D through F level deficiencies. At both levels of noncompliance, the most frequently missed deficiencies involved Quality of Care standards. Federal observational survey results and prior GAO reports have highlighted several factors that may contribute to the understatement of deficiencies.

[16]See GAO-03-561.

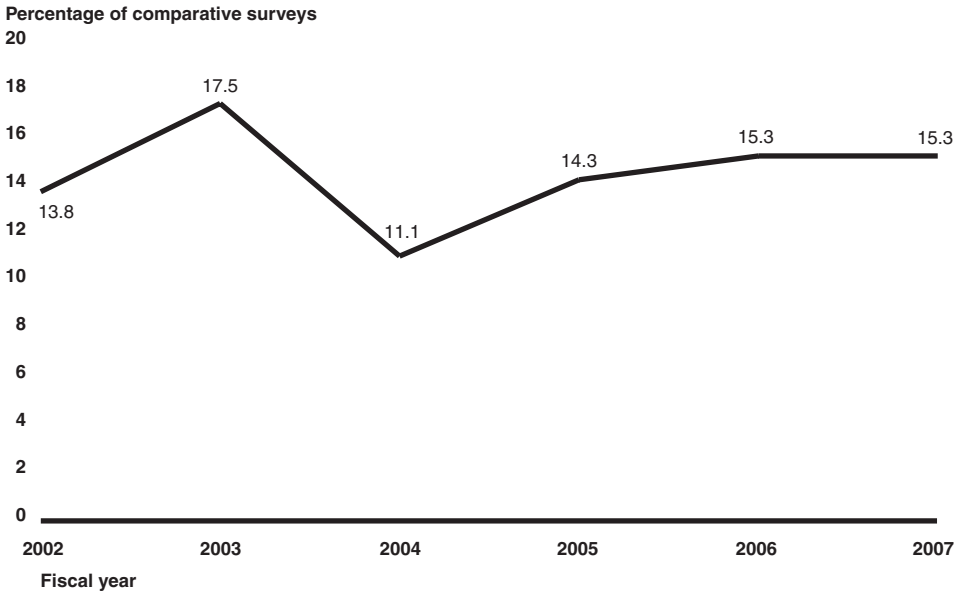
Small but Unacceptably High Proportion of Federal Comparative Surveys Found That State Survey Teams Missed Serious Deficiencies

Example of a Missed Deficiency at the Actual Harm Level

On a fiscal year 2006 comparative survey, federal surveyors found a G-level deficiency that the state survey team had not cited at any level. After verifying that the affected resident was part of the state survey sample and the evidence used by federal surveyors was available at the time of the state survey, the federal surveyors commented that "The resident had an avoidable, unplanned weight loss of 11 [percent] in [6] months from June to November 9, 2005. There was no nutritional assessment that addressed the 11 percent weight loss for November 2005 and the physician was not aware of the resident's weight loss."

About 15 percent (142) of the 976 comparative surveys conducted from fiscal year 2002 through 2007 identified state surveys that missed at least one deficiency at the actual harm or immediate jeopardy level (G through L), the most serious levels of noncompliance. This proportion fluctuated from a high of 17.5 percent in fiscal year 2003 to a low of 11.1 percent in fiscal year 2004, but it has remained relatively constant at about 15 percent for the last several fiscal years (see fig. 1). This proportion is small, but CMS maintains that any missed serious deficiencies are unacceptable.

Figure 1: Percentage of Comparative Surveys Nationwide Citing at Least One Missed Deficiency at the Actual Harm or Immediate Jeopardy Level, Fiscal Years 2002 through 2007



Source: GAO analysis of federal monitoring survey data.

From fiscal year 2002 through 2007, federal surveyors identified missed serious deficiencies in 25 percent or more of their comparative surveys in nine states. The proportion of missed serious deficiencies in these nine states ranged from 26.3 percent in Tennessee to 33.3 percent in New Mexico, South Carolina, South Dakota, and Wyoming (see table 2).[17] The

[17]We examined missed deficiencies by state for each fiscal year from 2002 through 2007 and found that for most states the failure to cite deficiencies at the actual harm and immediate jeopardy levels was not isolated to a single year during the 6 fiscal years we examined, and it continued to be a problem for many states in fiscal year 2007.

total number of missed deficiencies at the G through L levels also varied across these nine states, from a low of 4 in South Dakota to a high of 19 in South Carolina. Federal surveyors identified no missed serious deficiencies in seven states (see app. II for complete state results).[18]

Table 2: States with 25 Percent or More of Comparative Surveys Identifying Missed Deficiencies at the Actual Harm or Immediate Jeopardy Levels, Fiscal Years 2002 through 2007

State	Number of homes in fiscal year 2007	Total comparative surveys	Total comparative surveys with at least one missed G-L deficiency	Percentage of total comparative surveys with at least one missed G-L deficiency	Total number missed G-L deficiencies
New Mexico	72	12	4	33.3	9
South Carolina	176	18	6	33.3	19
South Dakota	112	12	4	33.3	4
Wyoming	39	12	4	33.3	5
Oklahoma	348	20	6	30.0	11
Missouri	530	28	8	28.6	14
Alabama	233	18	5	27.8	13
Arizona	137	15	4	26.7	6
Tennessee	332	19	5	26.3	10

Source: GAO analysis of federal monitoring survey data.

[18]Alaska, Idaho, Maine, North Dakota, Oregon, Vermont, and West Virginia had no missed serious deficiencies.

Missed Deficiencies at the Potential for More Than Minimal Harm Level Were Widespread on Federal Comparative Surveys

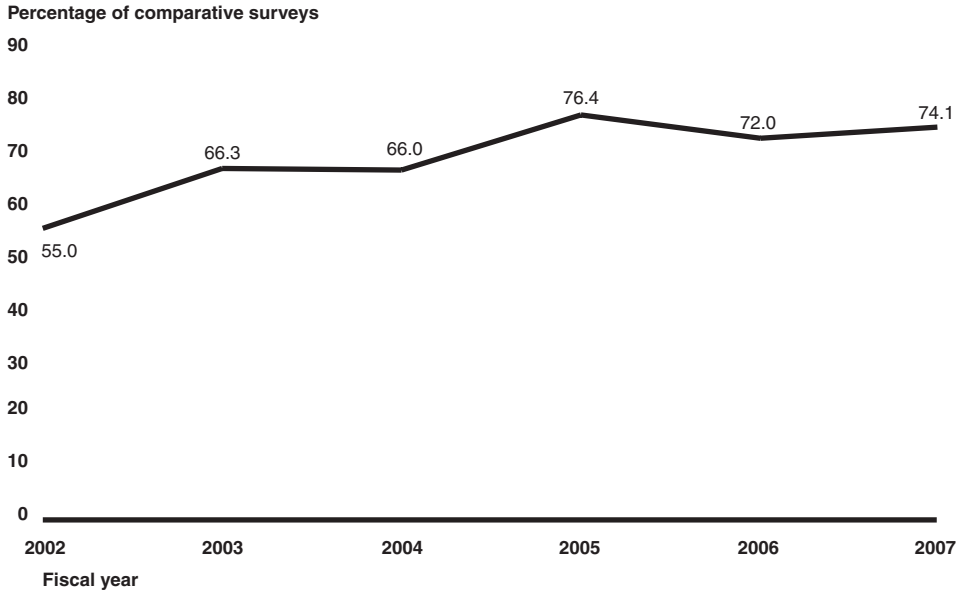
Example of a Missed Deficiency at the Potential for More Than Minimal Harm Level

On a fiscal year 2007 comparative survey, federal surveyors found an F-level deficiency—that is, a deficiency widespread throughout the facility—that the state survey team had not cited at any level. After verifying that the evidence used by federal surveyors was available at the time of the state survey, the federal surveyors commented that "Deficiency [is] based on a systemic lack of monthly drug reviews dating back to June 2006. [State surveyors] would have been expected to cite this deficient practice."

In contrast to missed serious deficiencies, missed deficiencies at the potential for more than minimal harm level (D through F) were considerably more widespread on comparative surveys conducted during fiscal years 2002 through 2007. Approximately 70 percent of comparative surveys conducted nationwide identified state surveys that missed at least one deficiency at the potential for more than minimal harm level (D through F), with such missed deficiencies identified on greater than 40 percent of comparative surveys in all but five states—Alaska, Ohio, Vermont, West Virginia, and Wisconsin.[19] On average, state surveys selected for comparative surveys failed to identify 2.5 D through F level deficiencies per survey. Undetected care problems at the D through F level are of concern because they could become more serious over time if nursing homes are not required to take corrective actions. Missed deficiencies at the potential for more than minimal harm level were not isolated to a single year during the 6 fiscal years we examined and continued to be a problem for states in fiscal year 2007. Nationally, the proportion of comparative surveys identifying at least one missed D through F level deficiency in fiscal year 2007 was about 74 percent (see fig. 2). For results by state, see appendix III.

[19]This finding was consistent with the overall prevalence of D through F level deficiencies cited by state survey teams during annual standard surveys. Approximately 84 percent of all deficiencies identified during these surveys in 2006 were at the D through F level. In contrast, only about 5 percent of deficiencies cited on state surveys were at the actual harm and immediate jeopardy (G through L) levels.

Figure 2: National Percentage of Comparative Surveys Citing at Least One Missed Deficiency at the Potential for More Than Minimal Harm Level, Fiscal Years 2002 through 2007



Source: GAO analysis of federal monitoring survey data.

Most Frequently Missed Deficiencies Involved Quality of Care

Our analysis found that the most frequently missed deficiencies at both the potential for more than minimal harm (D through F) and the actual harm or immediate jeopardy (G through L) levels occurred in quality standards under CMS's Quality of Care category. Missed deficiencies in this category involved residents' receipt of the necessary care and services to attain and maintain the highest practicable physical, mental, and psychosocial well-being—such as prevention of pressure sores, nutrition and hydration, accident prevention, and assistance with bathing and grooming.

From fiscal year 2002 through 2007, 11.9 percent of federal comparative surveys (116) cited at least one Quality of Care deficiency at the actual harm or immediate jeopardy level that state survey teams failed to cite. These 116 surveys contained a total of 143 missed serious Quality of Care deficiencies. The category with the next highest frequency of missed serious deficiencies was Resident Behavior and Facility Practices, with

only 2.2 percent of total federal comparative surveys.[20] At the potential for more than minimal harm level, Quality of Care was one of two categories with the highest frequency of missed deficiencies—31.7 percent.[21] For the percentage of missed deficiencies in each of the CMS quality standard categories, see appendix IV.

Federal Observational Surveys and Prior GAO Reports Identified Factors That May Contribute to Deficiency Understatement by State Survey Teams

Both federal observational surveys and our prior reports have identified factors that may contribute to the understatement of deficiencies by state survey teams. From fiscal year 2002 through 2007, 80 percent of the 4,999 federal monitoring surveys were observational. Our review of observational survey data—which are collected during direct observation of state survey teams—found that some of the lowest state survey team ratings nationwide were in the General Investigation and Deficiency Determination areas. Together, these two areas directly affect the appropriate identification and citation of deficiencies.

- The General Investigation segment of an observational survey evaluates the effectiveness with which the state survey team collected information to determine how the facility's environment and care of residents affect residents' quality of life, health and safety, and ability to reach their highest practicable physical, mental, and psychosocial well-being. This segment includes observations of state survey team actions such as collection of information, discussion of survey observations, interviews with facility residents, and implementation of CMS investigative protocols.

- The Deficiency Determination segment of an observational survey evaluates the skill with which the state survey teams (1) integrate and analyze all information collected and (2) use the guidance to surveyors and regulatory requirements to make accurate compliance determinations. This segment includes observations of state survey team actions such as reviews of regulatory requirements, team participation in deficiency discussions, presentation of complete information, accurate decision making, and accurate citation of deficiencies.

[20]Examples of deficiencies related to Resident Behavior and Facility Practices include resident abuse and the misuse of restraints.

[21]In addition, 31.7 percent of total comparative surveys found at least one missed potential for more than minimal harm level deficiency in the Resident Assessment category. An example of a deficiency related to Resident Assessment is the failure to develop a comprehensive care plan that meets a resident's physical, mental, and psychosocial needs.

Nationwide, 7.7 percent of the state survey teams observed by federal surveyors received below satisfactory ratings on the General Investigation measure from fiscal year 2002 through 2007.[22] During the same 6 fiscal years, 9.2 percent, or about 1 in 11, of the state survey teams observed by federal surveyors received below satisfactory ratings on the Deficiency Determination measure. Our analysis found variation across states in survey team performance in General Investigation and Deficiency Determination. Sixteen states had more teams than the national average receive below satisfactory ratings for both measures, while 28 states had fewer teams than the national average receive below satisfactory ratings (see app. V).[23]

Poor performance on these observational survey measures may be a contributing factor to the understatement of deficiencies by state survey teams. For example, of the nine states in table 2 with the highest percentage of missed serious deficiencies on comparative surveys, six had more teams than the national average receive below satisfactory ratings for both General Investigation and Deficiency Determination (see table 3).[24]

[22]Federal observational surveys use a five-point rating scale to evaluate state survey teams. Our analysis collapsed the ratings in the lowest two categories—much less than satisfactory and less than satisfactory—into a single category of below satisfactory results.

[23]An additional seven states had mixed performance on these two measures—performing above the national average for one measure and below the national average for the other.

[24]Later in this report, we observe that no Wyoming and South Dakota survey teams received below satisfactory ratings on observational surveys.

Table 3: States with 25 Percent or More of Comparative Surveys with Missed Deficiencies and Percentage of Their Observational Surveys with Less Than Satisfactory Ratings on General Investigation and Deficiency Determination, Fiscal Years 2002 through 2007

	Percentage of state observational surveys with below satisfactory ratings		
State	General investigation	Deficiency determination	Percentage of comparative surveys that found at least one missed G-L deficiency
Alabama	20.0	22.7	27.8
Arizona	7.4	15.4	26.7
Missouri	17.6	22.1	28.6
New Mexico	26.3	31.6	33.3
Oklahoma	12.1	16.5	30.0
South Carolina	14.3	22.9	33.3
South Dakota	0.0	0.0	33.3
Tennessee	14.6	20.7	26.3
Wyoming	0.0	0.0	33.3
Nation	**7.7**	**9.2**	**14.5**

Source: GAO analysis of federal monitoring survey data.

Our prior reports have described some other factors that may contribute to survey inconsistency and the understatement of deficiencies by state survey teams: (1) weaknesses in CMS's survey methodology, such as poor documentation of deficiencies;[25] (2) confusion about the definition of actual harm;[26] (3) predictability of surveys, which allows homes to conceal problems if they so desire;[27] (4) inadequate quality assurance processes at the state level to help detect understatement in the scope and severity of

[25]See GAO-03-561 and GAO-07-794T. In response to our recommendation to finalize the development, testing, and implementation of a more rigorous survey methodology, CMS developed and is currently evaluating a revised survey methodology.

[26]See GAO-06-117.

[27]See GAO-03-561. Our analysis of survey predictability considered surveys to be predictable if (1) homes were surveyed within 15 days of the 1-year anniversary of the prior survey or (2) homes were surveyed within 1 month of the maximum 15-month interval between standard surveys. We used this rationale because homes know the maximum allowable interval between surveys, and those whose prior surveys were conducted 14 or 15 months earlier are aware that they are likely to be surveyed soon.

deficiencies;[28] and (5) inexperienced state surveyors as a result of retention problems.[29] In ongoing work, we are investigating the factors that contribute to understatement.

CMS Has Taken Steps to Improve the Federal Monitoring Survey Program, but Weaknesses in Management and Oversight Remain

CMS has taken steps to improve the federal monitoring survey program, but weaknesses remain in program management and oversight. For example, CMS has improved processes to ensure that comparative surveys more accurately reflect conditions at the time of the state survey, has switched control of the federal monitoring survey database to the office responsible for ensuring the effectiveness of state surveys, and has begun examining how to use monitoring survey data to improve oversight. Despite this progress, the management and oversight potential of the program has not been fully realized. In particular, CMS (1) has only begun exploring options for identifying understatement that occurs in cases where state surveys cite deficiencies at too low a level, for possible implementation in fiscal year 2009, and (2) is not effectively managing the federal monitoring survey database or using the database to oversee consistent implementation of the federal monitoring survey program by its regional offices.

CMS Policy Changes Have Improved Federal Monitoring Surveys

CMS has taken steps in three areas—time between surveys, resident sample, and survey resources—to ensure that comparative surveys more accurately capture the conditions at the time of the state survey.

- **Time between surveys**. In fiscal year 2002, CMS initiated a policy that shortened the length of time between state and comparative surveys from 2 months to 1 month. CMS relaxed the 1 month standard by changing the requirement to 30 working days in fiscal year 2003. As a result of shortening the time between the two surveys, the conditions at the time of the comparative survey are more likely to reflect those at the time of the state survey; for example, the same residents are still likely to be in the nursing home. Comparative surveys during fiscal year 2007 took place on average 21.4 working days (30.9 calendar days) after state surveys.

[28]See GAO-03-561.

[29]See GAO-03-561.

- **Resident sample**. Beginning in fiscal year 2003, CMS policy required that comparative surveys include at least half of the residents from state survey investigative samples. Officials from several regional offices said that examining the same resident allows for more clear-cut determinations of whether the state should have cited a deficiency. Since the policy change, about 78 percent of comparative surveys from fiscal year 2003 through 2007 included at least half the residents from state surveys' investigative samples. By comparison, only 13 percent of comparative surveys met that 50 percent threshold in fiscal year 2002, the year before the policy went into effect.

- **Survey resources**. Beginning in fiscal year 2003, CMS initiated a policy that each comparative survey should have the same number of federal surveyors as its corresponding state survey, again to more closely mirror the conditions under which the state survey was conducted.[30] We found that in fiscal year 2007, the average state survey team (3.4 surveyors) was larger than the average federal survey team (3.0 surveyors). However, on average, federal surveyors remained on-site longer than state surveyors—4.3 days for federal surveyors compared with 3.7 days for state surveyors. When the number of surveyors and time on-site are taken together, state surveys averaged 12.6 surveyor-days and federal comparative surveys averaged 12.9 surveyor-days.[31]

  Given these improvements, we asked the regional offices how receptive state survey teams were to feedback that they had missed deficiencies. Most regional office officials told us that in general the feedback session with state surveyors on missed deficiencies was not contentious and that state surveyors generally accepted the feedback provided. However, CMS established a formal dispute resolution process for comparative surveys in October 2007. The process is similar to the process already in place for resolving disagreements about observational survey results.[32]

[30]On a comparative survey, CMS does not evaluate the adequacy of state survey team staffing.

[31]Surveyor-days are calculated as the total number of days on-site times the number of surveyors who worked full-time on that nursing home survey. If three surveyors were on-site and the survey took 3 days, then the survey would have used 9 surveyor-days.

[32]Because the establishment of the dispute resolution process for comparative surveys is relatively recent, we did not assess how often states challenge comparative findings.

Federal Monitoring Survey Database Has Not Been Used to Capture Understatement of Scope and Severity Levels

While CMS requires federal surveyors to determine whether a deficiency cited on a comparative but not a state survey was missed by state surveyors, there is no comparable requirement for deficiencies that are cited at different scope and severity levels. As a result, comparative surveys do not effectively capture the extent of the understatement of serious deficiencies by state surveyors. As with missed deficiencies, a discrepancy between federal and state survey results does not automatically indicate understatement. For example, the deficiency could have worsened by the time of the federal survey.

Although CMS does not require federal surveyors to evaluate scope and severity differences between the two sets of surveys, we found that some regional offices used the validation question for missed deficiencies—"based on the evidence available to the [state], should the [state survey] team have cited this [deficiency]?"—to make such a determination.[33] Using the validation question to make these determinations is contrary to CMS guidance issued in October 2003, which instructed comparative survey teams to only answer this question when the state failed to cite the deficiency altogether.

To assess whether differences in scope and severity levels were actually understated—rather than deficiencies that worsened between the state and federal surveys—we first identified all 71 deficiencies on comparative surveys conducted from fiscal year 2002 through 2007 where federal survey teams cited actual harm or immediate jeopardy deficiencies that state survey teams cited at a lower scope and severity level.[34] We then examined the comment fields in the federal monitoring survey database associated with those deficiencies. Our analysis identified 27 deficiencies (38 percent) in which federal survey teams determined that a state's scope and severity citation was too low. For another 22 deficiencies (31 percent), federal survey teams found that the state's lower scope and severity

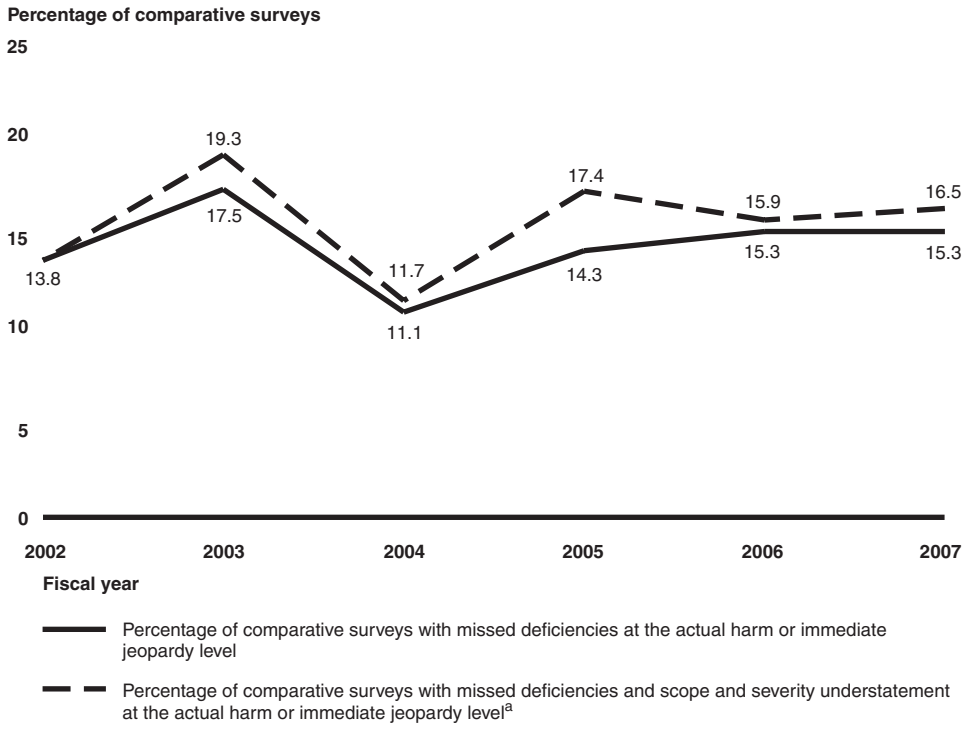
[33]Five of the 10 CMS regions made determinations on multiple occasions about whether the state "should have cited" a deficiency, even though the only discrepancy was the scope and severity level.

[34]We did not examine the 388 instances where federal survey teams cited potential for more than minimal harm deficiencies and state survey teams cited the same deficiencies at a lower scope and severity level.

determination was appropriate, given the circumstances at the time of the state survey. The remaining 22 deficiencies (31 percent) did not have comments or contained remarks that were inconclusive about whether the state deficiency citation was too low. When the confirmed scope and severity understatement was included with understatement caused by missed deficiencies, the total percentage of comparative surveys with understatement of serious deficiencies increased by an average of about 1 percentage point over the 6 fiscal years we analyzed (see fig. 3).[35]

[35]Overall, federal surveyors identified understated scope and severity levels on 2.4 percent of state surveys during fiscal years 2002 through 2007. The 1 percent average increase in the total percentage of comparative surveys is lower because comparative surveys with both types of understatement—failing to cite a deficiency or citing a deficiency at too low a scope and severity level—were counted only once.

Figure 3: Percentage of Comparative Surveys Nationwide with Understatement of Actual Harm and Immediate Jeopardy Deficiencies, with Scope and Severity Differences Included, Fiscal Years 2002 through 2007



Source: GAO analysis of federal monitoring survey data.

[a]The inclusion of scope and severity understatement is based on our analysis of 71 deficiencies that federal survey teams cited as actual harm or immediate jeopardy deficiencies that state survey teams cited at a lower scope and severity level.

While CMS headquarters does not require federal surveyors to determine whether a deficiency cited by state survey teams was cited at too low a scope and severity level, some regional offices have developed their own procedures to track this information and use it to provide feedback to state survey agencies. For example, in one regional office an individual reviews all comment fields for a year's worth of comparative surveys, makes a hand count of scope and severity differences that states should have cited, and then shares this with the state survey agencies during their annual performance reviews. Because the federal monitoring survey database does not automatically collect data on scope and severity determinations, CMS headquarters does not have access to the data analyses the regions have independently conducted. Some of the regional offices told us that they would like to have a specific way that the federal

monitoring survey database could track scope and severity understatement that is similar to how deficiencies missed by state surveyors are tracked.

In January 2008, CMS officials told us that they had initiated a pilot program in October 2007 to test the collection of data on understatement of scope and severity differences.[36] According to CMS, the pilot, which will run through 2008 for possible fiscal year 2009 implementation, is necessary because the agency needs to determine which scope and severity understatement differences should be captured. For example, CMS is uncertain whether regions should only focus on differences that would raise the scope and severity level to actual harm or immediate jeopardy and not assess differences for understatement that occurs at lower scope and severity levels.

CMS Could More Effectively Manage the Federal Monitoring Survey Database and Use It for Regional Office Oversight

Our analysis found that CMS headquarters was not effectively managing the federal monitoring survey database or using the database to oversee consistent implementation of the federal monitoring survey program by regional offices.[37] While CMS uses data from comparative and observational surveys to provide feedback to state survey agencies during state performance reviews, CMS officials told us that they recognized the need to improve their management and use of the database for better oversight of the agency's 10 regional offices.

We identified two problems in CMS's management of the federal monitoring survey database. CMS was not aware that (1) the results of a considerable number of comparative surveys were missing from the database and (2) the validation question for missed deficiencies was being used by some regional offices to identify scope and severity differences, contrary to CMS guidance.

[36]CMS became aware in October 2007 that some regional offices were using the validation question designed to identify missed deficiencies when our preliminary analysis identified missing data in several regions.

[37]Officials from CMS's Survey and Certification Group—the component responsible for ensuring the effectiveness of state survey activities—assumed control of the database in January 2007 from CMS's Division of National Systems. While officials from the Survey and Certification Group are still familiarizing themselves with the database, they stated that this change in control was necessary to move it closer to the component responsible for managing the federal monitoring survey program.

- **Missing data**. In October 2007, we identified missing comparative surveys for two regional offices dating back to 2005 and asked CMS to follow up with officials in those regions. At least one of the regions had completed the surveys but had failed to upload them into the national database.[38] We also found that CMS had not included data in the federal monitoring survey database from 162 contractor-led comparative surveys conducted between fiscal years 2004 and 2007.[39]

- **Use of validation question contrary to CMS guidance**. Some regional offices were using the missed deficiency validation question to make determinations about whether scope and severity differences constituted understatement, making it difficult to distinguish between missed deficiencies and scope and severity understatement. In addition, we found that the regional office answer to the validation question was not always consistent with the information recorded in the comment box.

  Similarly, we identified weaknesses in CMS's use of the database for regional office oversight. For example, CMS was not (1) examining comparative survey data to ensure that regional offices comply with CMS guidance intended to ensure that comparative surveys more accurately capture the conditions at the time of the state survey and (2) using the database to identify inconsistencies between comparative and observational survey results.

- **Ensuring regional office compliance**. While CMS has provided guidance to its regional offices to help ensure that comparative surveys more accurately capture the conditions at the time of the state survey, the agency is not fully using available data to ensure that the regional offices implement the agency's guidance. For example, we found that the length of time between state and comparative surveys varied broadly by CMS region. In 2007, the average time gap ranged from a low of 15.4 working days (22.5 calendar days) in the Boston region to a high of 38.5 working days (54.4 calendar days) in the New York region. Furthermore, while 78 percent of comparative surveys from fiscal year 2003 through 2007

[38]Subsequently, CMS informed us that all comparative surveys from the two regions were now accessible in the database.

[39]CMS indicated that the results of contractor-led comparative health surveys—which began in fiscal year 2004—are not included in the federal monitoring survey database because those surveys are in addition to the federal monitoring surveys required by statute and that inclusion of the contractor-led data would hinder CMS's ability to collect and analyze data about CMS staff resources that are devoted to comparative surveys.

followed CMS's guidance to include at least half of the residents from state surveys' investigative samples, 22 percent of comparative surveys did not meet this threshold. Finally, when we contacted officials in CMS headquarters to ask clarifying questions about the data variables needed to conduct these analyses, the headquarters officials were not familiar with a number of the variables and referred us to a CMS staff person in one of the regional offices. Together, these three examples suggest that CMS is not effectively using the data to hold regional offices accountable for implementing guidance.

- **Identify inconsistencies between comparative and observational results**. CMS officials told us that they have begun to explore regional office differences in less than satisfactory ratings for state survey teams on observational surveys.[40] However, CMS officials told us that they do not plan to use the database to identify inconsistencies between comparative and observational surveys that may warrant follow-up to ensure that regional offices are adhering to CMS guidance and consistently assessing state surveyor performance.[41] For example, some states that performed below the national average in identifying serious deficiencies on comparative surveys received above-average marks on observational survey measures for Deficiency Determination and General Investigation. Wyoming's 33.3 percent rate for surveys with missed serious deficiencies was more than double the national average of about 15 percent for surveys conducted during fiscal years 2002 and 2007. Yet Wyoming never received a below satisfactory rating on its General Investigation or Deficiency Determination measures during 18 observational surveys over that same 6-year period. We found similar inconsistencies in the results of federal monitoring surveys for South Dakota and a few other states. Although inconsistencies between comparative and observational surveys may not necessarily indicate a problem, they may warrant investigation. For example, in a small state like Wyoming it is likely that comparative and observational surveys have evaluated the same group of state surveyors. Further, Wyoming and South Dakota are two of six states whose federal monitoring surveys are conducted by CMS's Denver regional office. Of the 140 observational surveys conducted from fiscal year 2002 through 2007, federal surveyors from the Denver regional office gave one below

[40]However, CMS officials told us that they have been unable to identify whether region-to-region differences were the result of inconsistencies in state survey agency performance or regional variation among nursing homes.

[41]Comparative and observational surveys each measure some of the same skills required for effective surveying, particularly state survey team general investigative techniques and ability to accurately identify deficiencies.

satisfactory rating on the Deficiency Determination measure. That 0.7 percent rate of below satisfactory performance was more than four times lower than the regional office with the next-lowest percentage—the Chicago regional office—which awarded below satisfactory ratings to 3.3 percent of state survey teams it observed.

Conclusions

With about 1 in 6 comparative surveys concluding that state survey teams had missed a serious deficiency or understated its scope and severity level, it is evident that state survey agency performance limits the federal government's ability to obtain an accurate picture of how often nursing home residents face actual harm or are at risk of serious injury or death. These missed serious deficiencies most frequently involved Quality of Care, reflecting shortcomings in fundamental provider responsibilities such as ensuring proper nutrition and hydration, accident prevention, and preventing pressure sores. Observational survey results also underscore problems state surveyors may face in identifying facility deficiencies; about 1 in 11 state survey teams nationwide were rated as below satisfactory by CMS surveyors on the Deficiency Determination measure.

We found that comparative survey data may mask the true extent of understatement because CMS's current protocol does not require regional offices to track in the federal monitoring survey database when state surveyors cite lower-than-appropriate scope and severity levels. As we conducted our work, CMS officials recognized this problem and in October 2007 began to experiment with a pilot program to measure understated scope and severity. However, at the conclusion of the pilot, scheduled for fiscal year 2008, CMS may decide not to implement a validation question for all scope and severity differences. We believe it is important to assess differences for understatement that occurs at the D through L levels—potential for more than minimal harm, actual harm, and immediate jeopardy.

We also found that CMS was not effectively managing the federal monitoring survey database to ensure that regional offices were entering data in a timely and consistent fashion. Lack of accurate and reliable data hinders effective oversight. For example, we found that the database was missing a considerable number of comparative surveys. Further, CMS has not used the federal monitoring survey database to its full potential as an oversight tool. For example, CMS is not fully using data on comparative surveys to ensure that regional offices are implementing guidance intended to improve federal monitoring surveys. Although CMS's Survey and Certification Group assumed control of the database in January 2007,

headquarters staff often referred us to CMS regional office staff to answer specific database questions, suggesting a lack of familiarity with the organization and content of the database. In addition, agency officials told us that they do not plan to follow up on inconsistencies between comparative and observational survey results that could indicate weaknesses in how regional offices evaluate state surveyors' performance. Identifying and following up on such inconsistencies could help ensure database reliability and hold regional office officials accountable for their implementation of the federal monitoring survey program, a program required by statute.

Recommendations for Executive Action

To address weaknesses in CMS's management of the federal monitoring survey database that also affect the agency's ability to effectively track understatement, we recommend that the Administrator of CMS take the following two actions:

- Require regional offices to determine if there was understatement when state surveyors cite a deficiency at a lower scope and severity level than federal surveyors do and to track this information in the federal monitoring survey database.
- Establish quality controls to improve the accuracy and reliability of information entered into the federal monitoring survey database.

To address weaknesses that affect CMS's ability to oversee regional office implementation of the federal monitoring survey program, we recommend that the Administrator of CMS take the following two actions:

- Routinely examine comparative survey data and hold regional offices accountable for implementing CMS guidance that is intended to ensure that comparative surveys more accurately capture the conditions at the time of the state survey.
- Regularly analyze and compare federal comparative and observational survey results.

Agency Comments

In written comments on our draft report, HHS indicated that it fully endorsed and would implement our four recommendations intended to strengthen management and oversight of the federal monitoring survey program. The comments generally outlined CMS's implementation plan through 2009 and indicated that some steps, such as improved

management of the federal monitoring survey database, are already under way. HHS's comments are reproduced in appendix VI.

The majority of HHS's comments focused on its strategic approach to improving oversight: (1) ensuring that all nursing homes are surveyed at least once every 15 months, (2) improving surveyor understanding of federal quality requirements through improved guidance and training, (3) increasing the consistency of state surveys through the introduction of a new nursing home survey methodology, and (4) improving the use of data generated by federal monitoring surveys. Many of these strategies aim to address the underlying causes of understatement, the topic of a forthcoming GAO report. HHS also noted that limitations in the Medicare survey and certification budget underscore the agency's need to target resources effectively to maximize results. For example, HHS indicated that the implementation of the new survey methodology will be dependent on the level of funding in the overall survey and certification budget through fiscal year 2014. Survey and Certification funding is the subject of another forthcoming GAO report.

Two of HHS's observations merit further discussion. First, HHS noted that understatement that arises from a lack of understanding or confusion about federal requirements would generally not be detected through federal monitoring surveys because both federal and state surveyors would be affected by the same limitation. We believe that the consistency with which federal surveys have identified serious deficiencies missed by state surveyors from fiscal year 2002 through 2007—about 15 percent, on average—suggests that federal surveyors have a better understanding of CMS quality requirements than do state surveyors. We have previously reported that the limited experience level of state surveyors because of the high turnover rate was a contributing factor to deficiency understatement.[42]

Second, HHS questioned our use of "one missed deficiency per survey" as a measure of understatement. We believe that this standard is appropriate for serious deficiencies that result in harm or immediate jeopardy (G through L level) because the goal of state surveys should be to identify and require nursing homes to address all such deficiencies. CMS itself uses this standard during annual state performance reviews. We also used this standard to describe the proportion of comparative surveys that identified

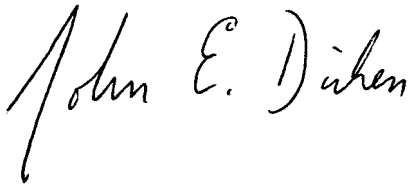
[42]See GAO-03-561 and GAO-06-117.

missed deficiencies at the potential for more than minimal harm level (D through F). Identifying and requiring nursing homes to correct such deficiencies is important because if uncorrected they have the potential to become more serious. Compared to missed serious deficiencies, we found that understatement of potential for more than minimal harm deficiencies was more widespread—about 70 percent of comparative surveys identified at least one state survey with such missed deficiencies. The number of state surveys with missed deficiencies at the D through F level was greater than 40 percent in all but five states, and state surveys selected for comparative surveys failed to identify an average of 2.5 deficiencies in this range per survey. In short, the magnitude of understatement at the potential for more than minimal harm level should be a cause for concern.

HHS also provided technical comments, which we incorporated as appropriate.

As arranged with your offices, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, we will send copies to the Administrator of the Centers for Medicare & Medicaid Services and appropriate congressional committees. We will also make copies available to others upon request. In addition, the report will be available at no charge on GAO's Web site at http://www.gao.gov.

If you or your staffs have any questions about this report, please contact me at (202) 512-7114 or dickenj@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix VII.



John E. Dicken
Director, Health Care

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

In order to identify trends in the percentage of nursing homes cited with actual harm or immediate jeopardy deficiencies, we analyzed data from the Centers for Medicare & Medicaid Service's (CMS) On-Line Survey, Certification, and Reporting system (OSCAR) database for fiscal years 2002 through 2007 (see table 4). Because homes must be surveyed at least every 15 months, with a required 12-month statewide average, it is possible that a home was surveyed more than once in any fiscal year. To avoid double counting homes, we included only a home's most recent survey from each fiscal year. Because CMS conducts a relatively small number of comparative surveys, it is not possible to compare the results of comparative surveys to the results of all state surveys.

Table 4: Percentage of Nursing Homes Cited for Actual Harm or Immediate Jeopardy, by State, Fiscal Years 2002 through 2007

		Fiscal year					
State	Number of homes in fiscal year 2007	2002	2003	2004	2005	2006	2007
Alabama	233	12.7	18.1	16.6	24.3	23.6	16.3
Alaska	15	26.7	0.0	0.0	0.0	26.7	13.3
Arizona	137	7.3	6.6	9.4	9.9	25.4	26.4
Arkansas	248	22.3	24.8	21.5	17.6	13.6	14.2
California	1,285	5.1	3.7	6.5	8.0	13.9	12.0
Colorado	212	32.7	20.9	25.9	40.4	43.8	42.4
Connecticut	244	45.8	43.1	55.4	44.2	46.5	38.3
Delaware	45	11.1	5.3	15.0	35.7	21.1	33.3
District of Columbia	20	30.0	41.2	40.0	30.0	25.0	36.8
Florida	683	14.9	10.2	8.6	4.2	8.0	8.3
Georgia	362	23.7	24.6	17.9	19.3	15.0	14.9
Hawaii	48	21.2	12.1	22.9	2.8	2.1	7.3
Idaho	79	39.2	31.9	27.3	40.5	44.9	27.1
Illinois	810	15.3	18.4	16.3	16.7	20.3	25.1
Indiana	520	23.2	19.7	24.5	29.6	30.6	35.2
Iowa	463	8.0	9.2	12.4	11.7	9.6	16.3
Kansas	358	32.9	26.5	31.9	36.6	37.7	29.4
Kentucky	293	23.2	26.1	15.0	8.0	10.6	7.6
Louisiana	299	21.8	16.2	13.8	16.3	16.1	11.7
Maine	113	6.6	11.1	12.8	7.0	9.8	7.2
Maryland	234	26.1	15.4	18.3	7.6	7.6	17.1
Massachusetts	452	24.6	25.9	17.4	22.9	20.6	16.6

State	Number of homes in fiscal year 2007	Fiscal year 2002	2003	2004	2005	2006	2007
Michigan	439	29.7	26.9	23.6	23.1	27.9	29.8
Minnesota	398	22.3	18.3	14.3	14.4	17.5	16.0
Mississippi	206	18.8	16.0	19.5	18.7	8.4	9.1
Missouri	530	15.6	12.5	12.5	15.8	15.2	15.5
Montana	96	12.0	20.0	18.0	17.9	16.7	23.9
Nebraska	228	20.1	14.8	15.8	14.4	25.0	26.4
Nevada	48	11.9	9.1	17.5	21.7	21.3	12.5
New Hampshire	81	29.4	24.4	25.6	26.3	22.9	14.7
New Jersey	368	18.8	10.5	12.9	18.2	14.6	16.5
New Mexico	72	14.9	21.3	25.7	32.4	25.0	28.6
New York	657	34.2	15.2	11.0	14.4	17.5	17.2
North Carolina	422	25.6	29.0	22.1	18.8	16.7	10.7
North Dakota	83	17.9	12.4	13.6	17.7	20.5	15.6
Ohio	984	25.4	19.1	11.8	14.4	13.4	14.4
Oklahoma	348	22.2	26.4	17.1	26.5	18.7	18.7
Oregon	139	23.7	20.3	16.7	18.9	17.8	17.6
Pennsylvania	724	13.5	17.2	19.9	15.5	12.0	11.9
Rhode Island	87	5.6	8.1	9.3	9.5	4.4	1.3
South Carolina	176	19.8	29.6	33.3	25.5	16.5	8.8
South Dakota	112	26.8	32.1	23.4	12.8	18.4	22.6
Tennessee	332	20.7	21.8	24.1	17.6	11.5	16.2
Texas	1,195	22.4	18.0	12.8	16.7	18.1	14.7
Utah	94	25.6	19.0	12.2	8.4	16.7	7.5
Vermont	41	15.0	10.0	19.5	23.7	13.5	12.1
Virginia	281	11.7	13.7	10.2	16.3	15.2	18.3
Washington	247	37.0	30.9	28.5	27.6	23.5	23.7
West Virginia	133	20.4	12.7	11.5	17.7	10.5	21.7
Wisconsin	401	11.2	10.9	13.1	18.8	21.6	29.8
Wyoming	39	25.0	22.9	17.1	11.8	16.2	24.2
Nation	**16,114**	**20.2**	**17.8**	**16.4**	**17.4**	**17.9**	**17.8**[a]

Source: GAO analysis of OSCAR data.

Note: Data presented in this table may be slightly different from those presented in earlier reports because we (1) used final year-end OSCAR files when they were available or (2) the OSCAR extracts contained surveys that had not previously been entered in the database.

[a]Fiscal year 2007 results are incomplete and use all available information as of January 2008.

Appendix II: Percentage of Comparative Surveys Identifying Missed Deficiencies at Actual Harm or Immediate Jeopardy Level

State	Number of homes in fiscal year 2007	Total comparative surveys	Total comparative surveys with at least one missed G-L deficiency	Percentage of total comparative surveys with at least one missed G-L Deficiency	Total number missed G-L deficiencies
Alabama	233	18	5	27.8	13
Alaska	15	11	0	0.0	0
Arizona	137	15	4	26.7	6
Arkansas	248	18	1	5.6	1
California	1,285	49	5	10.2	6
Colorado	212	22	3	13.6	4
Connecticut	244	16	1	6.3	1
Delaware	45	13	2	15.4	2
District of Columbia	20	12	1	8.3	1
Florida	683	26	3	11.5	6
Georgia	362	18	3	16.7	4
Hawaii	48	12	1	8.3	1
Idaho	79	12	0	0.0	0
Illinois	810	32	7	21.9	12
Indiana	520	25	3	12.0	4
Iowa	463	19	3	15.8	4
Kansas	358	24	4	16.7	8
Kentucky	293	18	2	11.1	2
Louisiana	299	17	3	17.6	6
Maine	113	12	0	0.0	0
Maryland	234	19	2	10.5	2
Massachusetts	452	17	1	5.9	1
Michigan	439	25	5	20.0	5
Minnesota	398	21	2	9.5	2
Mississippi	206	18	4	22.2	8
Missouri	530	28	8	28.6	14
Montana	96	12	2	16.7	2
Nebraska	228	18	1	5.6	1
Nevada	48	12	1	8.3	2
New Hampshire	81	14	2	14.3	2
New Jersey	368	24	5	20.8	16
New Mexico	72	12	4	33.3	9

State	Number of homes in fiscal year 2007	Total comparative surveys	Total comparative surveys with at least one missed G-L deficiency	Percentage of total comparative surveys with at least one missed G-L Deficiency	Total number missed G-L deficiencies
New York	657	27	6	22.2	12
North Carolina	422	21	3	14.3	3
North Dakota	83	12	0	0.0	0
Ohio	984	31	1	3.2	1
Oklahoma	348	20	6	30.0	11
Oregon	139	18	0	0.0	0
Pennsylvania	724	37	6	16.2	6
Rhode Island	87	12	2	16.7	3
South Carolina	176	18	6	33.3	19
South Dakota	112	12	4	33.3	4
Tennessee	332	19	5	26.3	10
Texas	1,195	38	5	13.2	7
Utah	94	11	1	9.1	1
Vermont	41	10	0	0.0	0
Virginia	281	17	1	5.9	1
Washington	247	18	2	11.1	2
West Virginia	133	13	0	0.0	0
Wisconsin	401	21	2	9.5	2
Wyoming	39	12	4	33.3	5
Nation	**16,114**	**976**	**142**	**14.5**	**232**

Source: GAO analysis of CMSs OSCAR data for the number of homes and federal monitoring survey data for all other data presente d.

Appendix III: Percentage of Comparative Surveys Identifying Missed Deficiencies with Potential for More Than Minimal Harm

State	Number of homes in fiscal year 2007	Total comparative surveys	Total comparative surveys with at least one missed D-F deficiency	Percentage of total comparative surveys with at least one missed D-F deficiency	Total number of missed D-F deficiencies
Alabama	233	18	17	94.4	61
Alaska	15	11	4	36.4	8
Arizona	137	15	12	80.0	73
Arkansas	248	18	13	72.2	50
California	1,285	49	36	73.5	104
Colorado	212	22	21	95.5	108
Connecticut	244	16	8	50.0	28
Delaware	45	13	9	69.2	29
District of Columbia	20	12	10	83.3	26
Florida	683	26	18	69.2	53
Georgia	362	18	13	72.2	48
Hawaii	48	12	7	58.3	22
Idaho	79	12	7	58.3	18
Illinois	810	32	17	53.1	63
Indiana	520	25	12	48.0	31
Iowa	463	19	13	68.4	36
Kansas	358	24	19	79.2	66
Kentucky	293	18	11	61.1	33
Louisiana	299	17	13	76.5	73
Maine	113	12	6	50.0	25
Maryland	234	19	9	47.4	16
Massachusetts	452	17	8	47.1	22
Michigan	439	25	18	72.0	37
Minnesota	398	21	15	71.4	29
Mississippi	206	18	15	83.3	57
Missouri	530	28	22	78.6	146
Montana	96	12	12	100.0	52
Nebraska	228	18	13	72.2	42
Nevada	48	12	11	91.7	33
New Hampshire	81	14	9	64.3	42
New Jersey	368	24	14	58.3	50
New Mexico	72	12	9	75.0	27
New York	657	27	15	55.6	77

State	Number of homes in fiscal year 2007	Total comparative surveys	Total comparative surveys with at least one missed D-F deficiency	Percentage of total comparative surveys with at least one missed D-F deficiency	Total number of missed D-F deficiencies
North Carolina	422	21	17	81.0	48
North Dakota	83	12	11	91.7	32
Ohio	984	31	12	38.7	20
Oklahoma	348	20	15	75.0	96
Oregon	139	18	12	66.7	30
Pennsylvania	724	37	23	62.2	66
Rhode Island	87	12	9	75.0	14
South Carolina	176	18	15	83.3	59
South Dakota	112	12	12	100.0	44
Tennessee	332	19	16	84.2	50
Texas	1,195	38	29	76.3	119
Utah	94	11	11	100.0	94
Vermont	41	10	4	40.0	18
Virginia	281	17	12	70.6	31
Washington	247	18	10	55.6	20
West Virginia	133	13	3	23.1	3
Wisconsin	401	21	8	38.1	19
Wyoming	39	12	12	100.0	83
Nation	**16,114**	**976**	**667**	**68.3**	**2,431**

Source: GAO analysis of CMS's OSCAR data for the number of homes and federal monitoring survey data for all other data presented.

Appendix IV: Percentage of Comparative Surveys with at Least One Missed Deficiency, by Federal Quality Standard Category

Federal quality standard category	Percentage of total comparative surveys citing at least one missed deficiency	
	At the D through F level	At the G through L level
Quality of Care	31.7	11.9
Resident Behavior and Facility Practices	17.7	2.2
Resident Assessment	31.7	1.6
Administration	13.3	1.4
Resident Rights	10.8	0.5
Quality of Life	18.9	0.5
Nursing Services	1.3	0.4
Other	0.2	0.2
Dietary Services	18.5	0.1
Physician Services	3.0	0.1
Dental Services	0.2	0.1
Pharmacy Services	9.7	0.1
Infection Control	9.8	0.1
Physical Environment	14.5	0.1
Admission, Transfer, and Discharge Rights	0.3	0.0
Specialized Rehabilitative	0.3	0.0
National average[a]	**68.3**	**14.5**

Source: GAO analysis of federal monitoring survey data.

[a]Percentages for both the D through F and G through L levels do not total the national average because some surveys cited missed deficiencies in multiple categories.

Appendix V: Percentage of Below Satisfactory State Survey Ratings for General Investigation and Deficiency Determination

State	Percentage of total comparative surveys with at least one missed G-L deficiency	Percentage of state surveys receiving below satisfactory ratings[a]	
		General Investigation	Deficiency Determination
Alabama	27.8	20.0	22.7
Alaska	0.0	5.3	5.3
Arizona	26.7	7.4	15.4
Arkansas	5.6	3.5	7.0
California	10.2	10.7	6.1
Colorado	13.6	4.7	0.0
Connecticut	6.3	7.4	7.4
Delaware	15.4	0.0	11.8
District of Columbia	8.3	5.6	5.6
Florida	11.5	16.6	19.5
Georgia	16.7	12.5	21.6
Hawaii	8.3	5.6	11.1
Idaho	0.0	5.6	0.0
Illinois	21.9	4.7	2.4
Indiana	12.0	2.3	3.9
Iowa	15.8	1.7	1.7
Kansas	16.7	2.3	4.7
Kentucky	11.1	11.4	21.4
Louisiana	17.6	14.9	19.4
Maine	0.0	12.5	4.2
Maryland	10.5	2.0	6.0
Massachusetts	5.9	0.8	0.8
Michigan	20.0	2.9	6.8
Minnesota	9.5	5.9	3.0
Mississippi	22.2	16.7	21.4
Missouri	28.6	17.6	22.1
Montana	16.7	10.5	0.0
Nebraska	5.6	4.1	2.0
Nevada	8.3	11.1	11.1
New Hampshire	14.3	25.0	18.8
New Jersey	20.8	3.3	1.1

State	Percentage of total comparative surveys with at least one missed G-L deficiency	Percentage of state surveys receiving below satisfactory ratings[a]	
		General Investigation	Deficiency Determination
New Mexico	33.3	26.3	31.6
New York	22.2	14.4	14.5
North Carolina	14.3	12.3	23.6
North Dakota	0.0	0.0	0.0
Ohio	3.2	0.8	2.7
Oklahoma	30.0	12.1	16.5
Oregon	0.0	4.3	8.7
Pennsylvania	16.2	4.3	5.3
Rhode Island	16.7	5.6	11.1
South Carolina	33.3	14.3	22.9
South Dakota	33.3	0.0	0.0
Tennessee	26.3	14.6	20.7
Texas	13.2	8.0	12.0
Utah	9.1	0.0	5.6
Vermont	0.0	0.0	0.0
Virginia	5.9	4.8	6.3
Washington	11.1	5.2	3.4
West Virginia	0.0	3.6	7.1
Wisconsin	9.5	6.1	3.0
Wyoming	33.3	0.0	0.0
Nation	**14.5**	**7.7**	**9.2**

Source: GAO analysis of federal monitoring survey data.

[a]Federal observational surveys use a five-point rating scale to evaluate state survey teams. Our analysis collapsed the ratings in the lowest two categories—much less than satisfactory and less than satisfactory—into a single category of below satisfactory results.

Appendix VI: Comments from the Department of Health & Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Assistant Secretary for Legislation

Washington, D.C. 20201

MAY 0 2 2008

Mr. John Dicken
Director, Health Care
Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Mr. Dicken:

Enclosed are the Department's comments on the U.S. Government Accountability Office's (GAO) Draft Report: "Nursing Homes: Federal Monitoring Surveys Demonstrate Continued Understatement of Serious Care Problems and CMS Oversight Weaknesses" (GAO-08-517).

The Department appreciates the opportunity to review and comment on this report before its publication.

Sincerely,

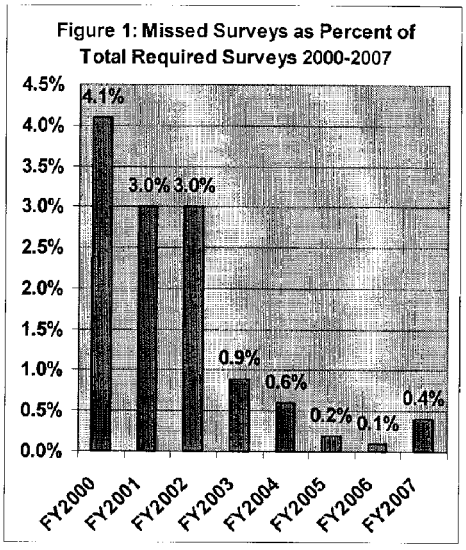
for Vincent J. Ventimiglia, Jr.
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE U.S. GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED: NURSING HOMES: FEDERAL MONITORING SURVEYS DEMONSTRATE CONTINUED UNDERSTATEMENT OF SERIOUS CARE PROBLEMS AND CMS OVERSIGHT WEAKNESSES (GAO 08-517)

The report was prepared at the request of the Special Committee on Aging and the Committee on Finance. The GAO evaluated the Centers for Medicare and Medicaid (CMS) oversight of States and potential understatement of deficiencies by States as States survey the nation's nursing homes.

We fully endorse and will implement all of the GAO recommendations. The GAO recommendations are consistent with the direction that CMS is taking. In the following remarks, we convey CMS' strategic approach for targeting scarce taxpayer dollars to areas in the Medicare and Medicaid quality assurance system that will yield the greatest benefit. We then discuss the GAO recommendations and the manner in which they relate to CMS activities. A strategic approach to quality requires that we establish clear priorities for action and then seek those leverage points by which we can achieve the greatest possible quality assurance results and protections for nursing home residents.



Leverage Point #1: Fixing "Missed" Surveys (A Key to Reducing "Missed" Deficiencies)

While the GAO report focuses on deficiencies that States may have missed when they conduct surveys, we placed an even higher priority on remedial action to prevent entire surveys from being missed. The Social Security Act, for example, requires that every nursing home be surveyed at least every 15 months. Yet this did not always occur. As a result of redoubled attention from CMS and States, the number and percent of surveys missed by States has decreased substantially (portrayed in **Figure 1**), despite well-known limitations in the Medicare survey and certification budget. In the process CMS strengthened the State Performance Standards System and introduced fiscal consequences when State performance did not fully meet standards. States responded by reducing missed surveys from 4.1 percent in fiscal year (FY) 2000 to 0.4 percent in 2007. When an entire survey is missed, all deficiencies are missed (not just those that State surveyors may have missed compared to Federal surveyors). Reducing the extent to which surveys were missed entirely has considerably reduced the overall number of missed deficiencies. CMS, therefore, continues to make the elimination of missed surveys one of its top priorities, a key strategy for improving overall oversight of nursing home quality within the resources appropriated to the Medicare and Medicaid survey and certification budget.

1

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE U.S. GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED: NURSING HOMES: FEDERAL MONITORING SURVEYS DEMONSTRATE CONTINUED UNDERSTATEMENT OF SERIOUS CARE PROBLEMS AND CMS OVERSIGHT WEAKNESSES (GAO 08-517)

Leverage Point #2: Improving Surveyor Knowledge and Understanding

Another high priority for CMS is ensuring that both State and Federal surveyors possess optimum understanding of both the care processes being surveyed and the Federal quality of care and safety requirements. CMS therefore placed a priority on surveyor training and clarifying interpretive guidance to all surveyors (both State and Federal). **Figure 2** lists the topic areas for which improved guidance was recently issued. Such guidance was accompanied by additional training.

Figure 2 – New Guidance to Surveyors to Improve Accuracy

Citation "F-Tags"	Topic	Implementation Date
314	Pressure Ulcers	November 14, 2004
315	Incontinence	June 27, 2005
501	Medical Director	November 18, 2005
520	Quality Assurance	June 1, 2006
248/249	Activities	June 1, 2006
	Psychosocial Severity Guidance	June 8, 2006
329, 425, 428, & 431	Unnecessary Drugs & Pharmacy Services	December 18, 2006
323	Accidents & Supervision	July 6, 2007

The goal of the guidance update initiative has been to improve accuracy and consistency, as well as keep pace with advances in the field. However, where understatement of deficiencies previously prevailed, an important by-product of the guidance update initiative has been to remedy understatement (or under-identification) of deficiencies. This is particularly important because understatement that arises from a lack of understanding or confusion about federal requirements would generally not be detected through the validation survey process that is the subject of the GAO report. The GAO report focuses on discrepancies that CMS detects by comparing the results of a sample of State surveys with results from federal surveys of the same facilities. If CMS requirements are unclear, then both Federal and State surveyors would be affected by the same limitation and a discrepancy between State and Federal surveys would be less likely to become manifest. Even more importantly, providers would be unclear.

One example of the impact that the guidance update initiative has had in curing under-identification of deficiencies can be seen in the rate at which the use of unnecessary drugs has been identified. **Figure 3** (on the following page) shows the change in citations of unnecessary drug use in nursing homes after

CMS issued better guidance and training in late 2006. Between 2000 and 2006, the percent of surveys in which the use of unnecessary drugs was identified consistently ranged between 13 percent and 14 percent. After the new guidance, the rate increased to 18 percent, reflecting surveyors' improved understanding of medication issues.

2

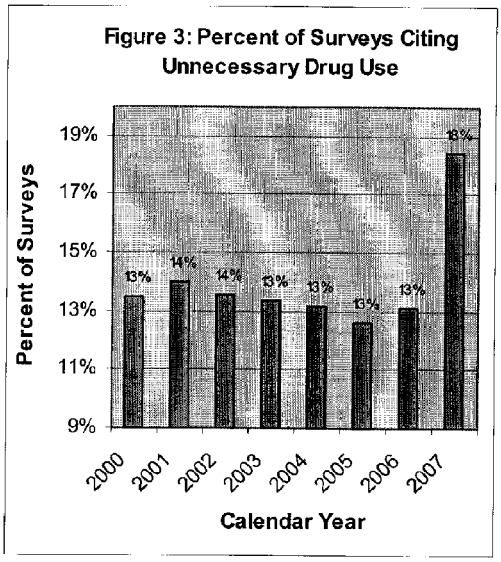
GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE U.S. GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED: NURSING HOMES: FEDERAL MONITORING SURVEYS DEMONSTRATE CONTINUED UNDERSTATEMENT OF SERIOUS CARE PROBLEMS AND CMS OVERSIGHT WEAKNESSES (GAO 08-517)

Leverage Point #3: Quality Indicator Survey

The Quality Indicator Survey (QIS) holds considerable promise for (a) improving CMS' validation capability, as well as (b) providing State Agency directors and supervisors with more tools to do their own validation analyses. As such, we believe it merits discussion in the context of our overall strategy for improving oversight.

The QIS is a new two–stage survey process used by surveyors to systematically review specific nursing home requirements and objectively investigate any regulatory areas that are triggered. The QIS uses customized software (Data Collection Tool-DCT) on tablet personal computers to guide surveyors through a structured investigation.

The QIS is currently being implemented statewide in eight States. Further expansion will be dependent on the level of funding in the overall Medicare and Medicaid survey and certification budget in FYs 2009-2014.



The QIS is not likely to increase the accuracy of deficiency identification, since accuracy may be more a function of training and CMS interpretive guidance. But we do expect that the QIS will have significant advantages directly pertinent to the quality control issues raised in the GAO report, such as the following:

1. **Consistency:** We expect the QIS to increase the consistency of survey process both between States and within States;

2. **Tools for State Quality Control:** We expect the QIS will provide better information and tools for State survey teams and supervisors to analyze findings and provide feedback to survey teams themselves. Information collected during the QIS supports an offsite monitoring process, which helps to ensure that State surveyors are complying with the QIS process. It also identifies areas of concern with regard to consistency and accuracy of survey performance.

3

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE U.S. GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED: NURSING HOMES: FEDERAL MONITORING SURVEYS DEMONSTRATE CONTINUED UNDERSTATEMENT OF SERIOUS CARE PROBLEMS AND CMS OVERSIGHT WEAKNESSES (GAO 08-517)

3. Tools for CMS Quality Control: We expect the QIS will provide better information and tools for CMS ROs to analyze findings and provide feedback to States. QIS information available to the RO provides comparison information at four levels - national, regional, State, and district within a State. Such information will assist the ROs to conduct quality improvement activities with the SAs in their region. Communications will occur between the RO and key SA staff using a process developed by the University of Colorado to help the SA understand and correct sources of inconsistency identified in a QIS. Certain standardized output reports assist both the State and the RO to identify areas in which quality improvement is needed. The "Desk Audit Reports" will also assist CMS to identify States and/or particular survey teams that need more specific training, technical assistance or oversight in order to improve accuracy of the surveys.

The same reports provided to the RO will be summarized and provided to the Central Office (CO). Review of this information at the CO creates the opportunity to evaluate the program for Federal monitoring at a macro or national level. We envision the CO utilizing this information to promote discussion with the RO regarding oversight of States. Use of the reports will focus on RO oversight, including the opportunity to discuss specific concerns that may be present at a State level.

Leverage Point #4: Improving CMS Validation Surveys as a Quality Control System

CMS ROs maintain a quality oversight system for surveys conducted by State surveyors. The essence of this validation system is a 5 percent sample of State surveys in which the ROs either (a) accompany State surveyors in which CMS staff observe both the surveyors and conditions in the nursing home (so-called "follow-along" or "Federal Oversight/Support Survey (FOSS)" surveys); or (b) conduct an independent survey of the nursing home within 60 days after the State survey (so-called "comparative" surveys). The ROs then compare the results and enter the information into CMS databases, noting any discrepancies in the findings between State and Federal survey teams. CMS ROs then follow-up with the States to address any deficiencies. The GAO report focuses entirely on this particular area using data that CMS maintains as part of its internal quality control system. CMS has been entirely successful in ensuring that 100 percent of required validation surveys are performed each year. This enables greater attention to be placed on improving the methodologies and use of the data. The GAO recommendations fit well with such a goal.

GAO Recommendations

1. Require regional offices to determine if there was an understatement when States cite a deficiency at a lower scope and severity level than Federal surveyors, and to track this information.
2. Establish quality controls to improve the accuracy and reliability of information entered into the Federal monitoring survey database.
3. Routinely examine comparative survey data and hold ROs accountable for implementing CMS guidance that is intended to ensure comparative surveys more accurately capture the conditions at the time of the State survey.

4

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE U.S. GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED: NURSING HOMES: FEDERAL MONITORING SURVEYS DEMONSTRATE CONTINUED UNDERSTATEMENT OF SERIOUS CARE PROBLEMS AND CMS OVERSIGHT WEAKNESSES (GAO 08-517)

4. Regularly analyze and compare Federal comparative and observational survey results.

HHS Responses

Recommendation #1 suggests that the Federal Monitoring Survey (FMS) database contain an explicit field for registering understatement of a deficiency. The current CMS database provides methods for CMS ROs to register where there are missed deficiencies. Yet the database does not have a specific field in which the RO can render a judgment to identify clearly those areas in which both the State and Federal teams identified the same deficiency, but cited it at a significantly different scope or severity level. We agree with the GAO recommendation and have planned for the future development of such capability as an action item in our *2008 Nursing Home Action Plan.* The *2008 Action Plan* can be found at: http://www.cms.hhs.gov/CertificationandCompliane/Downloads/2008NHActionPlan.pdf.

Recommendation #2 accurately reflects the fact that there have been problems in the FMS database that CMS maintains. CMS identified these problems a few years ago and took action in 2007 to move the FMS database and vendor contract to the CMS Survey & Certification Group in order to (a) bring it closer to the end users of the data and (b) facilitate integration of the data into the State Performance Standards System. Data entry and accuracy issues always become more prominent, and more likely to be remedied, the closer the data are to regular use in management of a program. Such remedial actions are well underway. **Figure 4** lists various steps for improving the FMS database. Attachment 1 provides additional information and timetables.

Figure 4: Steps to Improve the Federal Monitoring System Database	
January to June 2007	Move the database close to end users and procure a new contractor to maintain & update the database. (Completed)
Sept. 2007	Implement monthly teleconference calls with the contractor, CMS CO, and RO staffs. The purpose of the teleconference calls is to answer questions, accept suggestions for improving the database, and communicate updates. (Completed and held every month since Sept 2007)
Nov. 2007	Overcome glitches in the transition from operating components in CO, provide assistance in downloading data from ROs, including written instructions. (Completed)
Dec. 2007-June 2008	Institute CO monitoring of the database on a quarterly basis to assure that ROs are downloading data quarterly.
Jan. 2008 – Nov. 2009	Modify the database to develop data fields that will document and track discrepancies between RO and State Survey Agency (SA) scope and severity for every deficiency cited.
Feb. 2008 – Jan. 2009	Strengthen the database to improve the accuracy and reliability of the data entered.
Feb. 2008 – Nov. 2008	Issue a FOSS Database User's Manual. (Now in draft form)
Nov. 2008 – May 2009	Develop new analytic reports to provide RO and CO an analysis of the differences between comparative and observational survey results.

5

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE U.S. GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED: NURSING HOMES: FEDERAL MONITORING SURVEYS DEMONSTRATE CONTINUED UNDERSTATEMENT OF SERIOUS CARE PROBLEMS AND CMS OVERSIGHT WEAKNESSES (GAO 08-517)

Recommendation #3 suggests that CMS CO routinely examine comparative survey data and hold regional offices accountable for implementing CMS guidance. We intend to develop additional output reports that will be useful to both CO and RO in analyzing State performance. Processes to ensure that CMS validation surveys are conducted in conformance with CMS guidance are the subject of current CMS discussion and will be finalized later in 2008.

Recommendation #4 indicates the need for (a) regular analysis of the FMS data and (b) regular comparison between results from the two validation processes (comparative and observational). Additional output reports from the FMS database will assist in this effort. We will then identify further methods by which the analyses may be put to effective use. For example, the GAO report noted that available data could be better utilized to identify areas in which particular CMS ROs merit additional attention. This is an observation that will be an important focus for CMS' *2009 Nursing Home Action Plan.*

One aspect of quality control that we have not solved, and that the GAO report does not resolve, is the setting of appropriate thresholds for missed deficiencies. No system involving multiple parties will yield the identical result every time. An entire field of statistics is devoted to issues of inter-rater agreement. In the present case, the challenge is to identify the level of "missed deficiencies" that goes beyond statistical chance and beyond issues of inter-rater agreement to reveal a level of discrepancy that ought to give concern and demand response from CMS. GAO adopted a measure of "one missed deficiency per survey," and then counted the percentage of a State's surveys for which Federal surveyors identified one or more deficiencies that the State missed. It is not clear that "one missed deficiency per survey" is the proper standard, nor is it clear what percentage of a State's surveys ought to trigger assertive response even when the "one missed deficiency per survey" standard is used. In this sense, the GAO analysis is helpful but not conclusive. We will need to devote more thought to these matters so that we can make more effective use of the approach in the State Performance Standards System .

Regardless of the particular thresholds chosen, we do agree with GAO that effective follow-up with States must be assured when it is clear the State surveys exhibit a high level of discrepancy in survey findings compared to the Federal validation surveys. For example, GAO identified nine States in which more than 25 percent of the surveys indicated a missed deficiency at a very serious (G-L) level. We note that assertive follow-up actions have been made by CMS ROs or are occurring in most of these States. In Alabama, for example, the CMS RO issued a very pointed series of evidence-based performance communications in 2007 and raised performance issues to the top agency levels. CMS CO made a $90,421 deduction in Alabama's Medicare budget in 2008 due to 2007 performance issues. We are pleased to report that the State of Alabama is in the process of effectively responding to these problems in 2008. The State has recruited additional survey staff and made important organizational changes. FMS validation surveys indicate that the Alabama State surveyors have not missed any serious deficiency determinations so far in 2008.

Similarly, in Tennessee a new survey agency director was enlisted in October 2007, the State retrained all staff (utilizing CMS RO staff to assist in training for investigative skills and deficiency determinations). Based on two comparative FMS surveys so far in 2008, the State surveyors have not missed any serious deficiency findings.

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GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE U.S. GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED: NURSING HOMES: FEDERAL MONITORING SURVEYS DEMONSTRATE CONTINUED UNDERSTATEMENT OF SERIOUS CARE PROBLEMS AND CMS OVERSIGHT WEAKNESSES (GAO 08-517)

The GAO report noted that available data could be better utilized to identify areas in which particular CMS ROs merit additional attention. This is an observation that is an important focus of action for CMS' 2009 Nursing Home Action Plan.

Due to the well-known limitations in the Medicare survey and certification budget, it has been particularly important that CMS target its resources effectively and apply its knowledge of system leverage points to gain maximum results from scarce resources. We hope that our explanation of the four leverage points outlined in our response is useful in placing CMS actions in context. We appreciate the opportunity to respond to the GAO draft report

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ATTACHMENT 1

CMS ACTION PLAN: GAO-08-517 *NURSING HOMES: Federal Monitoring Surveys Demonstrate Continued Understatement of Serious Care Problems and CMS Oversight Weaknesses*

GAO Recommendation		CMS Action
A. **Regional Office Oversight**: Require ROs to determine if there was understatement when state surveyors cite a deficiency at a lower scope and severity level than Federal surveyors and track this information.	A1	FMS Database Users' Manual – As stated in our *2008 Nursing Home Action Plan*, CMS will issue instruction to the ROs that defines all data fields and includes procedures for entering all data into the FMS database. This document currently exists in draft form and will be finalized for release by November 30, 2008.
	A2	FMS Database – We will modify the FMS Database to allow tracking the variance between RO and State findings at the scope and severity level. The RO will be able to enter their findings, and production reporting capability will be developed to allow easy analysis of these data by November 30, 2009.
	A3	Communication between ROs and Central Office (CO) via Regular Teleconference Calls – We have implemented a system of regular conference calls between CO, a core group from the ROs, and the database contractor to answer questions, discuss best practices, suggest and communicate database improvements, set expectations, and provide updates.
B. **Quality Controls:** Establish quality controls to improve the accuracy and reliability of information entered into the Federal monitoring survey database.	B1	Strengthening the database – We will modify the database to incorporate additional edits (e.g., assuring that the correct data is entered in the appropriate data field before the surveyor can move onto the next data field).
	B2	RO Reporting – We will implement Quality Assurance reports by November 30, 2009 for use by the ROs. The reports will describe the results of their review of the accuracy and reliability of the data entered into the database. These reports will be sent to CO quarterly for assessment. We will routinely monitor the database to assure ROs are downloading data.
C. **Analysis & Follow-Up**: Routinely examine comparative survey data and hold regional offices accountable for implementing CMS guidance.	C1	Develop RO Start Date Reports – We will develop a report that will show the number of work days between the SA's comparative end date and the RO's start date. CMS will generate these reports quarterly for assessment. We will operationalize these reports no later than November 30, 2008.
	C2	RO Feedback Mechanism – We will implement by November 30, 2009 a feedback system based on RO reporting and CO analysis of comparative survey results. One component of this feedback system will be a standing agenda item on internal management meetings at least once a quarter.
D. **Compare Comparative & FOSS Data:** Regularly analyze and compare Federal comparative and observational survey results.	D1	RO Reporting – We will implement a system of QA reports for the ROs describing the results of their review of the accuracy and reliability of the data entered into the database. These reports will be sent to CO quarterly for assessment and begin no later than November 30, 2009.

Appendix VII: GAO Contact and Staff Acknowledgments

GAO Contact

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