Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

DEFICIENCY HISTORY AND RECERTIFICATION OF MEDICARE HOME HEALTH AGENCIES

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EXECUTIVE SUMMARY

OBJECTIVE

To determine:

1. the extent to which Medicare home health agencies (HHA) repeated the same deficiency citations across three consecutive surveys, and
2. whether the Centers for Medicare & Medicaid Services (CMS) uses deficiency history in its oversight of HHAs.

BACKGROUND

Medicare's home health benefit provides treatment for beneficiaries who have short- or long-term illnesses or injuries and who are confined to their homes. Services provided by a Medicare HHA include skilled nursing services, therapeutic services (physical and occupational therapy and speech-language pathology), home health aide services, medical social services, and certain medical supplies and equipment. In recent years, this benefit has grown in terms of Medicare beneficiaries receiving home health services, expenditures, and number of HHAs.

All HHAs participating in the Medicare program must be compliant with 15 Medicare Conditions of Participation (CoP) and 69 standards. CMS contracts with State agencies to conduct initial HHA certification and recertification surveys to determine CoP compliance. Since fiscal year 2006, pursuant to section 1891(c)(2)(A) of the Social Security Act, all HHAs have been subject to a recertification survey at least once every 36 months. In addition, State agencies annually survey a 5-percent targeted sample of at-risk HHAs. CMS uses an algorithm to identify at-risk HHAs. An HHA that receives one or more standard-level or condition-level deficiencies must respond to the State agency with a plan of correction. An HHA with one or more condition-level deficiencies must come back into compliance within 90 calendar days from the completed survey date. Noncompliance with one or more CoP is cause for termination of participation. Termination is the only sanction available to CMS in response to HHA noncompliance. CMS has not implemented intermediate sanctions against HHAs as directed by the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987).

The report findings are based primarily on analysis of data from CMS's Online Survey Certification and Reporting System (OSCAR). We analyzed survey data for 5,661 active Medicare-certified HHAs as of

January 11, 2007. We also interviewed staff at CMS headquarters and regional offices, State agencies, and HHAs.

FINDINGS

Fifteen percent of HHAs repeated the same deficiency citation on three consecutive surveys. These cyclically deficient HHAs' most frequently repeated deficiency citation is related to patient plans of care. On the three most recent surveys, these HHAs received, on average, twice as many deficiency citations per survey compared to HHAs that did not repeat citations. Among cyclically deficient HHAs, most are located in six States and tend to be concentrated in highly populated areas.

CMS oversight of HHAs could be improved. Currently, CMS does not use all available deficiency history information in its oversight of HHAs. We found that deficiency history beyond the most recent survey can be an important indicator of performance on the next survey and can improve CMS's identification of at-risk HHAs. For HHAs with one or more condition-level deficiencies, CMS has no sanction other than initiating a termination track.

RECOMMENDATIONS

Based on our findings, we recommend that CMS:

Use existing survey data to identify patterns of deficiency citations and at-risk HHAs. CMS should require surveyors to review all available survey data prior to each upcoming survey. In addition, CMS should include multiple survey results in its algorithm that identifies HHAs that are at risk of providing poor quality of care.

Implement intermediate sanctions as directed by the OBRA 1987. Currently, termination from the Medicare program is the only sanction for poor-performing HHAs. Intermediate sanctions may include civil money penalties, suspension of all or part of Medicare payments, and appointment of temporary management for cyclically deficient HHAs.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS generally concurred with our recommendations. CMS indicated that, during the last several years, it has implemented improvements to the oversight of HHAs, many of which address the issue of repeated deficiencies.

CMS concurred, in part, with the recommendation that the agency use existing survey data to identify patterns of deficiency citations and at-risk HHAs; specifically, that CMS require surveyors to review all available survey data prior to each upcoming survey. CMS noted that section 2200A of the "State Operations Manual" requires surveyors to review complaint data, previous survey data, and reports generated by the Outcome and Assessment Information Set system when preparing to conduct an onsite survey. The agency will issue the final version of this report to the regional offices and State survey agencies and reinforce the necessity of reviewing previous survey data.

CMS does not concur with the second part of this recommendation: that the agency include multiple survey results in the algorithm that identifies a targeted sample of HHAs that are at risk of providing poor quality of care. CMS suggests that including an algorithm of three standard surveys would result in newer HHAs, among others, not being included in the targeting process because these HHAs lack historical survey data. We excluded HHAs that did not meet the study criteria in order to determine clearly the relationship between repeat deficiencies and subsequent survey performance. However, CMS would not need to exclude any HHAs when using an algorithm that makes use of historical data. CMS could modify the algorithm to include any available historical survey data that have been weighted, as appropriate. HHAs with fewer than four surveys included in OSCAR would be assessed based on the survey data that are available. Our analysis demonstrates that historical data can improve CMS's ability to identify at-risk HHAs. CMS should use all available data to target those HHAs most at risk of providing poor quality of care.

As an alternative to modifying the algorithm to include historical survey data, CMS could conduct analysis similar to that described in this report to identify HHAs with repeated deficiencies across multiple surveys. CMS could provide this information to State survey agencies annually to help surveyors identify HHAs that may be in need of closer review, whether or not they appear in the targeted sample.

CMS concurred with the recommendation to implement intermediate sanctions as directed by the OBRA 1987. The agency indicated that changes in law and other regulations, together with the demands of additional improvement efforts, have impeded promulgation of the final rule. CMS outlined several initiatives it has undertaken during this time to address HHA performance and compliance.

TABLE OF CONTENTS

EXECUTIVE SUMMARY i

INTRODUCTION 1

FINDINGS 9

Fifteen percent of HHAs repeated the same deficiency citation on three consecutive surveys 9

CMS oversight of HHAs could be improved 11

RECOMMENDATIONS 14

Agency Comments and Office of Inspector General Response . . . 15

APPENDIXES 17

A: Medicare HHA Conditions of Participation and Standards . . . 17

B: HHA Survey Cycles Prior to Fiscal Year 2006 21

C: CMS's Algorithm to Identify Targeted Sample of At-Risk HHAs 22

D: Standard-Level Deficiency Citations That Account for Half of All Deficiencies Across the Three Most Recent Surveys for Cyclically Deficient HHAs 23

E: Metropolitan Statistical Areas With High Numbers of Cyclically Deficient HHAs 24

F: Agency Comments 25

ACKNOWLEDGMENTS 29

OBJECTIVE

To determine:

1. the extent to which Medicare home health agencies (HHA) repeated the same deficiency citations across three consecutive surveys, and
2. whether the Centers for Medicare & Medicaid Services (CMS) uses deficiency history in its oversight of HHAs.

BACKGROUND

Medicare Home Health Benefit and Medicare Expenditures

Medicare's home health benefit provides treatment for beneficiaries who have short- or long-term illnesses or injuries and who are confined to their homes.[1] Home health care is intended to reduce the need for hospitalization and institutionalization and to help beneficiaries maintain their independence and quality of life. To qualify for home health services, a Medicare beneficiary must be homebound, be under an established plan of care by a physician, and need at least one home health therapeutic service or intermittent skilled nursing service (e.g., intravenous or intramuscular injections, intravenous feedings).[2]

Services provided by a Medicare HHA include skilled nursing services, therapeutic services (physical and occupational therapy and speech-language pathology), home health aide services, medical social services, and certain medical supplies and equipment.[3] These services are provided by the HHA or are provided under arrangements made by the HHA, and they must be ordered and periodically reviewed by a physician. In addition, HHAs must maintain patient clinical records and be licensed pursuant to State and local law. By the end of 2006, there were approximately 8,800 Medicare-certified HHAs nationally.[4]

In recent years, the number of Medicare beneficiaries receiving home health services has grown along with expenditures for those services. From 2001 to 2005, the number of Medicare beneficiaries served by HHAs increased 23 percent. In 2005, HHAs provided services to almost

[1] Social Security Act § 1835(a), 42 U.S.C. § 1395n(a) (defining the term "confined to his home").

[2] 42 CFR § 409.42.

[3] Social Security Act § 1861(m), 42 U.S.C. § 1395x(m).

[4] CMS Online Survey Certification and Reporting (OSCAR) System as of January 12, 2007.

3 million Medicare beneficiaries who averaged 31 visits per person.[5] Expenditures for home health services increased almost 50 percent from $8.6 billion in 2001 to $12.8 billion in 2005.

HHA Conditions of Participation

All HHAs participating in the Medicare program must be compliant with 15 Medicare Conditions of Participation (CoP) and 69 standards.[6] The CoP are intended to ensure the quality of services provided by HHAs. The 15 HHA Medicare CoP fall into two areas: administration and furnishing of services. Twelve of the fifteen CoP are subdivided into standards, which address specific aspects of the condition. For example, the condition for clinical records includes standards that address the retention of records, the protection of records, record reviews, and evaluations of the HHA program. Among the 12 CoP that are subdivided, each condition can have from 1 to 23 standards. Three CoP are not subdivided by standards.[7] (See Appendix A for a list of all of the HHA CoP and standards.)

Quality-of-care measures. One HHA condition requires Medicare-certified HHAs to report and transmit patient assessment data, within 30 days of completing the assessment, using the reporting Outcome and Assessment Information Set (OASIS).[8] The OASIS is a group of data elements collected from each HHA patient used to manage and measure each patient's care and outcomes. For each HHA, CMS uses a subset of the OASIS data to calculate a score for 41 quality measures.[9] CMS provides scores for 12 of the 41 quality measures for each HHA on its Home Health Compare Web site.[10] These scores are updated quarterly.

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[5] CMS Health Care Information System data, 2007.

[6] Social Security Act § 1891(a), 42 U.S.C. § 1395bbb (a); 42 CFR pt. 484 (subparts B and C).

[7] The three CoP that are not defined further by standards are: qualifying to furnish outpatient physical therapy or speech pathology services (42 CFR § 484.38), medical social services (42 CFR § 484.34), and release of patient identifiable OASIS information (42 CFR § 484.11).

[8] 42 CFR § 484.20.

[9] A list of the 41 quality measures can be found at http://www.cms.hhs.gov/HomeHealthQualityInits/10_HHQIQualityMeasures.asp#TopOfPage. Accessed on April 8, 2008.

[10] CMS, "Information About Home Health Quality Measures." Available online at http://www.medicare.gov/HHCompare/Home.asp?dest=NAV|Home|DataDetails#TabTop. Accessed on February 26, 2008.

HHA Survey Process

HHA certification and recertification surveys. Pursuant to section 1891(b) of the Social Security Act, CMS is responsible for ensuring that the HHA CoP and their enforcement are adequate to protect the health and safety of individuals receiving home health services. To fulfill this duty, CMS contracts with State agencies to conduct initial HHA certification and recertification surveys (hereinafter referred to as surveys) to determine CoP compliance.[11] The State agency also may conduct a survey at any time in response to complaints from HHA patients or other sources.

During surveys, State agency surveyors (hereinafter referred to as surveyors) assess compliance with 7 of the 15 HHA CoP and the individual standards that fall within each, plus one additional HHA standard.[12][13] CMS selected these seven CoP and one additional standard because they are associated most closely with patient care. The seven HHA CoP and one standard are:

1. 42 CFR § 484.10 Condition of Participation: Patient Rights
2. 42 CFR § 484.11 Condition of Participation: Release of Patient Identifiable OASIS Information
3. 42 CFR § 484.12 Condition of Participation: Compliance with Federal, State, and Local Laws, Disclosure and Ownership Information, and Accepted Professional Standards and Principles
4. 42 CFR § 484.18 Condition of Participation: Acceptance of Patients, Plan of Care, and Medical Supervision
5. 42 CFR § 484.36 Condition of Participation: Home Health Aide Services
6. 42 CFR § 484.48 Condition of Participation: Clinical Records

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[11] Social Security Act § 1864(a), 42 U.S.C. § 1395aa (a).

[12] CMS "State Operations Manual," Pub. No. 100-07, ch. 2, § 2196.1A (rev. 1, May 21, 2004).

[13] An HHA may choose initial certification through one of three approved accrediting organizations with deeming authority–the Joint Commission on Accreditation of Healthcare Organizations, the Community Health Accreditation Program, and the Accreditation Commission for Healthcare. HHAs also may elect to be accredited and surveyed by one of the accrediting organizations. CMS "State Operations Manual," Pub. No. 100-07, ch. 2, § 2210B (rev.1, May 21, 2004) and ch. 1, § 1018D (rev. 1, May 21, 2004). Recently, CMS approved deeming authority for the Accreditation Commission for Healthcare. 71 Fed. Reg. 9564 (Feb. 24, 2006).

7. 42 CFR § 484.55 Condition of Participation: Comprehensive Assessment of Patients
8. 42 CFR § 484.14(g) Coordination of Patient Services (Standard)

To assess those standards relating to patient care, surveyors review a case-mix stratified sample of clinical records and then conduct home visits for patients receiving HHA services.[14] According to CMS policy, the number of record reviews and home visits varies based on the total number of unduplicated admissions requiring skilled services within a recent 12-month period.[15] For example, an HHA that served between 150 and 750 patients within a 12-month period will have a minimum of five to seven record reviews with home visits. In addition, the same HHA will receive 10 record reviews without a home visit.[16] Surveyors also conduct several record reviews with and without home visits for patients who each experienced an adverse event outcome (e.g., emergent care for an injury caused by a fall or accident at home).[17]

If an HHA has one or more standard-level or condition-level deficiencies, it is out of compliance and the surveyor provides the HHA with a Statement of Deficiencies and Plan of Correction form (Form CMS-2567) that includes evidence to support the deficiency citation.[18] The HHA must respond with a plan of correction within 10 calendar days of receiving the form.[19] An HHA with standard-level deficiencies is certified as in compliance by the State agency if the facility submits an acceptable plan of correction for achieving compliance within a reasonable period of time, which is generally no longer than 60 days after notification of the deficiencies.[20] An HHA with one or more condition-level deficiencies is considered to be providing substandard care and cannot be certified as in compliance by the State agency based solely on a plan of correction.[21] In these cases, the HHA is placed on a 90-day termination track and is required to submit a "credible

[14] CMS "State Operations Manual," Pub. No. 100-07, ch. 2, § 2200C4 (rev. 1, May 21, 2004).

[15] CMS "State Operations Manual," Pub. No. 100-07, ch. 2, § 2200C5 (rev. 1, May 21, 2004).

[16] CMS "State Operations Manual," Pub. No. 100-07, ch. 2, § 2200C6 (rev. 1, May 21, 2004).

[17] CMS "State Operations Manual," Pub. No. 100-07, ch. 2, §§ 2200C5 and 2200C6 (rev. 1, May 21, 2004).

[18] CMS "State Operations Manual," Pub. No. 100-07, ch. 2, §§ 2728 - 2728A (rev. 1, May 21, 2004).

[19] CMS "State Operations Manual," Pub. No. 100-07, ch. 2, §§ 2728 and 2728B (rev. 1, May 21, 2004).

[20] CMS "State Operations Manual," Pub. No. 100-07, ch. 2, § 2728B (rev. 1, May 21, 2004).

[21] CMS "State Operations Manual," Pub. No. 100-07, ch. 3, § 3012 (rev. 1, May 21, 2004).

allegation of compliance" before the State agency conducts at least one revisit to determine whether compliance or acceptable progress has been achieved.[22] [23]

Provisions in the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) directed CMS to implement intermediate sanctions against HHAs that are no longer in compliance with Federal requirements.[24] The Secretary of the Department of Health and Human Services was directed to develop and implement intermediate sanctions no later than April 1, 1989, which were to include civil money penalties, suspension of Medicare payments, and the appointment of temporary managers to problem HHAs.[25] CMS proposed intermediate sanctions in 1991 but never finalized the regulation.[26] As a result, the only remedy currently available to CMS in response to HHA noncompliance is termination.

Survey frequency. As mandated in statute, an HHA is subject to a recertification survey no later than 36 months from the previous recertification survey.[27] Prior to fiscal year 2006, an HHA's survey frequency could vary from every 12 months to every 36 months depending on the HHA's survey results.[28] For example, a new HHA was subject to a survey every 12 months for the first 3 years. If the HHA was deficiency-free for those 3 years, then it was placed on a 36-month survey schedule unless it received any deficiency citations on a subsequent survey. In addition to conducting routine scheduled surveys, State agencies annually selected and surveyed a 5-percent random sample of HHAs on the 36-month survey cycle.[29] (See Appendix B for further information on variable survey cycles prior to fiscal year 2006.)

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[22] Ibid. When an immediate jeopardy to patient health and safety is documented, the State agency will initiate a 23-day termination track. CMS "State Operations Manual," Pub. No. 100-07, ch. 3, § 3010B (rev. 1, May 21, 2004).

[23] "Credible allegation of compliance" is defined as "a statement or documentation: that is realistic in terms of the possibility of corrective action being accomplished between the exit conference and the date of allegation; and that indicates resolution of the problems." CMS "State Operations Manual," Pub. No. 100-07, ch. 3, § 3016A (rev. 1, May 21, 2004).

[24] OBRRA of 1987, P.L. No. 100-203 § 4023, Social Security Act § 1891(e)–(f), 42 U.S.C. 1395bbb (e)–(f).

[25] Social Security Act § 1891(f)(1).

[26] 56 Fed. Reg. 37054 (Aug. 2, 1991).

[27] Social Security Act § 1891(c)(2)(A). A recertification survey is a "standard survey" as it is referred to in the statute.

[28] CMS "State Operations Manual," Pub. No. 100-07, ch. 2, § 2195 (rev. 1, May 21, 2004).

[29] CMS "State Operations Manual," Pub. No. 100-07, ch. 2, § 2195.E (rev. 1, May 21, 2004).

Since fiscal year 2006, CMS simplified its variable survey cycle with a new system.[30] Instead of being subjected to variable survey cycles, all HHAs now are subject to recertification surveys at least once every 36 months. In addition to these surveys, CMS uses a 5-percent targeted sample that replaced the annual 5-percent random sample. The targeted sample is generated by an algorithm that identifies HHAs at greatest risk of failing to provide quality care. (See Appendix C for further information on the algorithm.) CMS indicates that it is using targeted sampling to utilize limited Medicare resources more effectively.[31] Also, CMS no longer requires State agencies to survey HHAs 12 months after the initial certification survey.

METHODOLOGY

Scope

As of January 11, 2007, CMS's OSCAR contained records for 18,731 Medicare-certified HHAs. OSCAR maintains survey deficiency information for the four most recent surveys. To limit our analysis to active HHAs, we excluded 9,908 HHAs with termination dates. Also, we excluded 157 HHAs with deemed status because the State agency does not conduct routine recertification surveys on these HHAs. Deemed status is received when an HHA chooses certification through an approved accreditation organization. After we excluded deemed HHAs and those with termination dates, 8,666 active Medicare-certified HHAs remained in our study population.

Analysis

In this report, we refer to HHAs that have at least one deficiency citation repeated on three consecutive surveys as cyclically deficient. For the purpose of describing our methodology, we refer to the four surveys in OSCAR numerically as 1, 2, 3, and 4 – Survey 1 being the most recent survey conducted of that HHA and Survey 4 being the oldest survey in OSCAR.

[30] CMS, Division of Survey and Certification, "Quality Assurance for the Medicare & Medicaid Programs, FY 2006 Mission & Priority Document," August 5, 2005. Through 2008, CMS continues to apply this new system. CMS, Division of Survey and Certification, "Quality Assurance for the Medicare & Medicaid Programs, FY 2008 Mission & Priority Document," August 8, 2007.

[31] Ibid.

For each of the two findings in this report, we analyzed data for a different subset of HHAs as shown in Table 1 below. We identified cyclically deficient HHAs for each subset.

Table 1. Subsets of HHAs in the Report

Type of HHA Subset	Number of Active Medicare-Certified HHAs	At Least One Deficiency Repeated on Survey 1, 2, and 3	At Least One Deficiency Repeated on Survey 2, 3, and 4
HHAs with three or four surveys (Subset used for the first finding.)	5,661	873	
HHAs with four surveys (Subset used for the second finding.)	5,011		655

Source: Office of Inspector General analysis of CMS survey data, 2008

To determine the current extent of cyclical deficiency among Medicare-certified HHAs for the first finding, we analyzed OSCAR results from Surveys 1, 2, and 3 (i.e., the three most recent surveys). Of the 8,666 active Medicare-certified HHAs in OSCAR, we excluded 3,005 HHAs that did not have at least three consecutive surveys with at most 42 months between surveys or did not have surveys within 42 months of January 11, 2007.[32] We chose 42 months, which includes the 36-month survey cycle and up to 6 months for the State agency to complete the survey, as the maximum amount of time between surveys.[33] From the remaining 5,661 HHAs, we identified 873 HHAs that each had at least one condition- or standard-level deficiency citation repeated on Survey 1, 2, and 3.

As part of the second finding, to determine how cyclically deficient HHAs performed on the subsequent survey, we identified each HHA that had at least one deficiency repeated on Survey 2, 3, and 4 (i.e., cyclically deficient on the three consecutive surveys prior to the most recent survey). We then compared the survey performance on Survey 1 (the most recent survey) of these cyclically deficient HHAs to all other HHAs. Of the 8,666 active Medicare-certified HHAs in OSCAR, we excluded 3,655 HHAs that did not have four consecutive surveys with at most 42 months between surveys or did not have

[32] We contacted CMS's Region V office to determine why some HHAs had current surveys longer than 3 years ago. The regional office indicated that either the HHA had deemed status or the State agencies had not entered the most recent survey results into OSCAR.

[33] Currently, there is no CMS guidance regarding timely uploading of survey results into OSCAR.

surveys within 42 months of January 11, 2007. From the remaining 5,011 HHAs, we identified 655 HHAs that each had at least one condition- or standard-level deficiency citation repeated on Surveys 2, 3, and 4. To determine the use of deficiency history in the oversight of HHAs, these HHAs also were used in an analysis with CMS's 5-percent targeted sample for fiscal year 2006.

In addition, we conducted structured interviews with staff from CMS's Survey and Certification Group and surveyors from CMS's regional offices and State agencies. We also visited several HHAs to gather information about the survey process and HHA operations.

Limitations

Our study is limited to the information in OSCAR. This study did not assess the survey process or the accuracy of CMS data in OSCAR.

Standards

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

Fifteen percent of HHAs repeated the same deficiency citation on three consecutive surveys

As of January 11, 2007, 873 HHAs (15 percent) repeated at least one deficiency citation on each of their three most recent surveys. Many cyclically deficient HHAs repeated more than one deficiency citation across multiple surveys. Of the 873 cyclically deficient HHAs, 366 (42 percent) repeated at least two of the same citations on each of their three most recent surveys, and 47 (5 percent) repeated the same five or more citations. Most cyclically deficient HHAs repeated standard-level citations; only six HHAs had a condition-level deficiency repeated on each of their three most recent surveys.

The most frequently repeated deficiency citation is related to patient plans of care

The 10 most frequently repeated deficiency citations, among cyclically deficient HHAs, are standard-level deficiencies and account for 79 percent of all repeated citations. (See Table 2 on the next page for a list of the top 10 deficiencies.)

Four of the ten deficiencies (G158, G159, G164, and G165) are associated with standards in the acceptance of patients, plan of care, and medical supervision condition.[34] These four deficiency citations account for 48 percent of all repeated citations among cyclically deficient HHAs. Of 873 cyclically deficient HHAs, 404 (46 percent) received a repeated citation for not demonstrating that the written plan of care was reviewed by the patient's physician (G158). The other three deficiency citations show that the written plan of care did not cover pertinent diagnoses (G159), the agency staff did not alert the physician of changes in the patient's condition (G164), and the agency staff did not administer drugs or treatments as ordered by the physician (G165).

[34] Each standard and condition is affiliated with a specific G tag (e.g., G158). CMS uses G tags to identify deficiencies on the Statement of Deficiencies and Plan of Correction form.

Table 2. The 10 Most Frequently Repeated Standard- and Condition-Level Deficiency Citations Among Cyclically Deficient HHAs		
Standard-Level Deficiency Citation* (associated condition) (G tag)	**Percentage of All 1,662 Repeated Deficiency Citations**	**Of the 873 Cyclically Deficient HHAs, Number of HHAs That Repeated the Citation****
1. Written plan of care established and periodically reviewed by a doctor. (Acceptance of patients, plan of care, and medical supervision.) (G158)	24.3%	404
2. Plan of care covers all pertinent diagnoses. (Acceptance of patients, plan of care, and medical supervision.) (G159)	15.3%	255
3. Clinical record maintained in accordance with accepted professional standards. (Clinical records.) (G236)	12.6%	209
4. The comprehensive assessment must include a review of all medications the patient is currently taking. (Comprehensive assessment of patients.) (G337)	8.5%	141
5. Agency professional staff promptly alerts the physician to any changes in the patient's condition. (Acceptance of patients, plan of care, and medical supervision.) (G164)	5.2%	86
6. Drugs and treatments are administered by agency staff only as ordered by the physician. (Acceptance of patients, plan of care, and medical supervision.) (G165)	3.0%	50
7. All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. (Organization, services, and administration.) (G143)	2.9%	49
8. Registered nurse regularly reevaluates the patient's nursing needs. (Skilled nursing services.) (G172)	2.5%	41
9. Registered nurse (or another professional described in paragraph (d)(1) of this section) must make an onsite visit to the patient's home no less frequently than every 2 weeks. (Home health aide services.) (G229)	2.5%	41
10. A written summary report for each patient is sent to the attending physician at least every 60 days. (Organization, services, and administration.) (G145)	2.4%	40
Total	**79.2%**	

Source: Office of Inspector General analysis of CMS survey data, 2007.

*For complete descriptions, refer to CMS's "State Operations Manual," Pub. No. 100-07, Appendix B (rev. 11, August 12, 2005).

**The column "Of the 873 Cyclically Deficient HHAs, Number of HHAs That Repeated the Citation" does not sum to 873 because HHAs may be cited for more than one deficiency.

Cyclically deficient HHAs received twice as many deficiency citations

On the three most recent surveys, cyclically deficient HHAs received, on average, 11.3 deficiency citations per survey compared to 5.7 citations for those HHAs that did not repeat citations. The most frequently cited deficiency citations across the three surveys are similar for cyclically deficient HHAs and those HHAs that did not repeat citations. (See Appendix D for a list of standard-level deficiencies that account for half of all deficiencies across the three most recent surveys for cyclically deficient HHAs.)

Cyclically deficient HHAs are concentrated in several States

Of the cyclically deficient HHAs, 64 percent (556 of 873) are located in six States – California, Florida, Illinois, Iowa, Michigan, and Texas.

However, only 30 percent of all HHAs in our study population are from these six States. In California, Illinois, and Michigan, more than half of HHAs are cyclically deficient. Highly populated areas within five of the six States (except Iowa) contain a greater percentage of cyclically deficient HHAs compared to the rest of the State. For example, three metropolitan areas in California contain 76 percent (61 of 80) of cyclically deficient HHAs in the State.[35] Approximately 68 percent of all HHAs in California are in these three metropolitan areas. One metropolitan area in Illinois contains 74 percent (117 of 159) of cyclically deficient HHAs in the State, whereas only 55 percent of HHAs in Illinois are in this metropolitan area. (See Appendix E for the distribution of cyclically deficient HHAs in the States mentioned above.)

CMS oversight of HHAs could be improved

CMS conducts surveys as part of its oversight of HHAs. Currently, State agencies conduct recertification surveys at least once every 36 months for each HHA. In addition, State agencies annually conduct surveys of a 5-percent targeted sample of at-risk HHAs. Prior to each survey, surveyors are required to review previous survey data in addition to outcome reports and complaint data.[36] However, surveyors are not required to review all past survey data in OSCAR. We found that deficiency history, beyond the most recent survey, can be an important indicator of performance on the next survey.

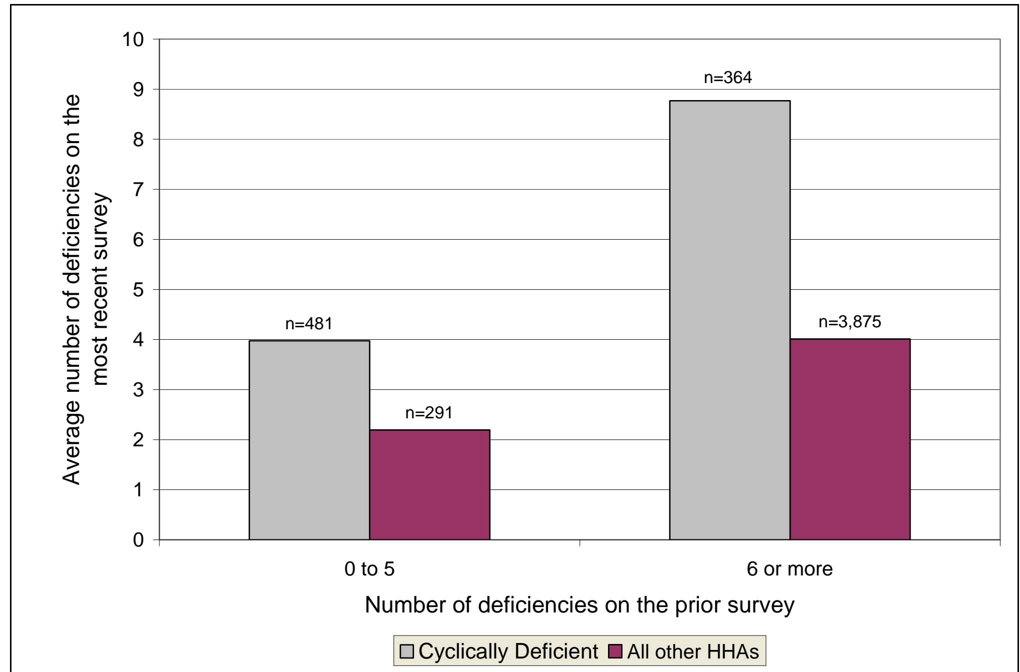
Cyclically deficient HHAs performed worse on the next survey than other HHAs

We identified 655 cyclically deficient HHAs that repeated at least one deficiency on the three consecutive surveys prior to the most recent survey. Chart 1 on the next page shows that they went on to receive more deficiencies, on average, than other HHAs on the most recent survey. This difference was more pronounced among HHAs with at least six deficiencies on the prior survey.

[35] A "metropolitan area" refers to a metropolitan statistical area as defined by the Office of Management and Budget and based on U.S. Census Bureau data. A metropolitan area has at least one urbanized area with a population of 50,000 or more.

[36] CMS "State Operations Manual," Pub. No. 100-07, ch. 2, § 2200A (rev. 1, May 21, 2004).

Chart 1. Cyclically Deficient HHAs, on Average, Received More Deficiencies on the Next Survey Than Other HHAs



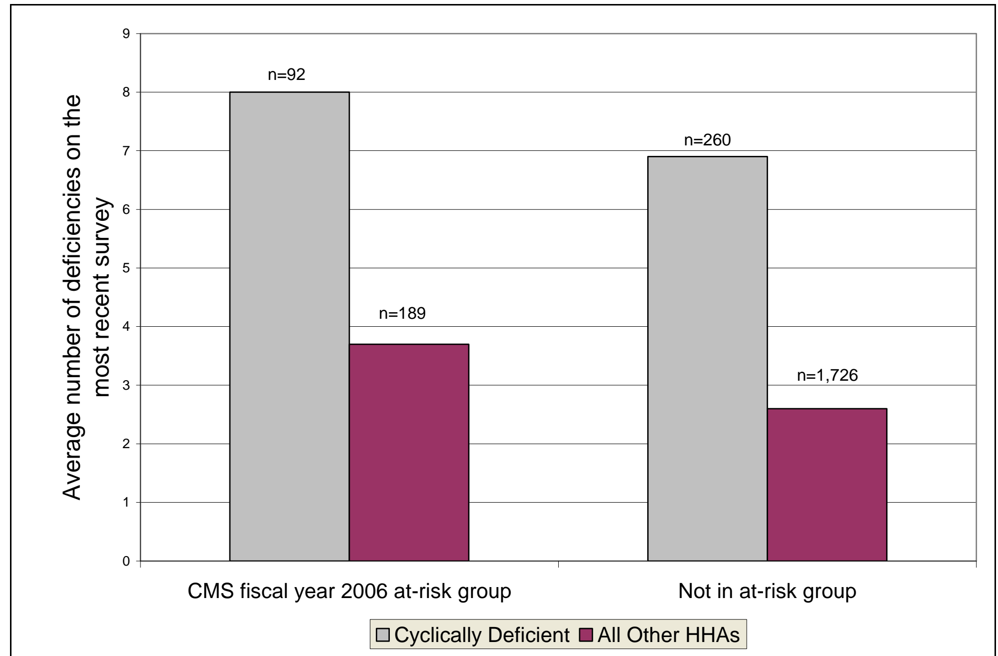
Source: Office of Inspector General analysis of CMS survey data, 2008.

Cyclically deficient HHAs performed worse on the next survey than at-risk HHAs without a history of cyclical deficiencies

Although CMS's algorithm identifies at-risk HHAs, it can target HHAs better by including deficiency history information such as repeated deficiency citations. As shown in Chart 2 on the next page, cyclically deficient HHAs that were not identified as at-risk by CMS's algorithm for fiscal year 2006 received, on average, 6.9 deficiencies on their most recent survey. This is greater than the average of 3.7 deficiencies among at-risk HHAs without a history of cyclical deficiencies.[37]

[37] We excluded 33 HHAs for which the prior survey (Survey 2) occurred after October 1, 2005, because information about cyclical deficiencies would not have been available when CMS identified at-risk HHAs for fiscal year 2006. We also excluded 2,711 HHAs for which the most recent survey (Survey 1) occurred before October 1, 2005, because we wanted to limit this analysis to HHAs for which performance on the most recent survey was unknown at the time CMS identified at-risk HHAs for fiscal year 2006.

Chart 2. Cyclically Deficient HHAs Performed Worse Among Both At-Risk HHAs and Not At-Risk HHAs



Source: Office of Inspector General analysis of CMS survey data, 2008.

CMS's sanction options for HHAs with deficiency citations are limited

For HHAs with one or more condition-level deficiencies, CMS has no sanction other than initiating a termination track. An HHA that receives one or more condition-level deficiencies is required to submit a plan of correction and is subject to at least one revisit by the State agency to determine whether compliance has been achieved. An HHA that receives only standard-level deficiencies is required to submit an acceptable plan of correction before being certified as in compliance. Although provisions in the OBRA 1987 directed CMS to implement intermediate sanctions for HHAs that failed to correct deficiencies, CMS did not finalize the regulation. Therefore, termination from the Medicare program remains the only Federal sanction for HHAs with deficiency citations, and it is used only rarely. In 2006, there were only 21 involuntary HHA terminations.

An analysis of HHA deficiency history data shows that 15 percent of HHAs are cyclically deficient. Furthermore, HHAs with repeated deficiencies perform worse on subsequent surveys. However, CMS does not use deficiency history in its oversight of HHAs. Also, for HHAs with one or more condition-level deficiencies, CMS has no sanction other than initiating a termination track. Based on our findings, we recommend that CMS:

Use Existing Survey Data To Identify Patterns of Deficiency Citations and At-Risk HHAs

CMS should require surveyors to review all available survey data prior to each upcoming survey. Because CMS uses the number of deficiencies as an element to identify at-risk HHAs, cyclically deficient HHAs could be considered at risk because they generally receive more citations. Identifying repeat deficiency areas could help surveyors and HHAs identify areas for improvement. In addition, CMS could focus efforts on those States with large numbers of cyclically deficient HHAs.

CMS should include multiple survey results in its algorithm that identifies the targeted sample of HHAs that are at risk of providing poor quality of care. Because HHAs with a history of cyclical deficiencies perform worse on subsequent surveys, deficiency history can be an important indicator of future performance. Currently, the algorithm does not include results from surveys conducted prior to the most recent survey. As a result, CMS and surveyors may miss HHAs in need of more frequent review. CMS could incorporate prior survey data from OSCAR into the algorithm.

Implement Intermediate Sanctions as Directed by the OBRA 1987

Currently, termination from the Medicare program is the only sanction for poorly performing HHAs. We found that the most frequently cited deficiency for cyclically deficient HHAs identify problems related to patient plans of care. In some cases, termination may be the appropriate action. However, less severe sanction options could be effective in addressing performance problems that do not immediately jeopardize patient health and safety. Options for additional sanctions may include civil money penalties, suspension of all or part of Medicare payments, and appointment of temporary management for cyclically deficient HHAs.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS generally concurred with our recommendations. CMS indicated that during the last several years, it has implemented improvements to the oversight of HHAs, many of which address the issue of repeated deficiencies. These changes include: (1) oversight of branch locations, (2) the addition of new OASIS reports, (3) increased training of surveyors, (4) identification of a targeted sample of HHAs, and (5) the development of a State Performance Standards System.

CMS concurred, in part, with the recommendation that the agency use existing survey data to identify patterns of deficiency citations and at-risk HHAs; specifically, that CMS should require surveyors to review all available survey data prior to each upcoming survey. CMS notes that section 2200A of the "State Operations Manual" requires surveyors to review complaint data, previous survey data, and reports generated by the OASIS system when preparing to conduct an onsite survey. The agency will issue the final version of this report to the regional offices and State survey agencies and reinforce the necessity of reviewing previous survey data. We recommend that CMS specifically instruct surveyors to review data beyond the most recent survey and to highlight patterns of noncompliance such as repeat deficiencies across multiple surveys.

CMS does not concur with the second part of this recommendation: that the agency include multiple survey results in the algorithm that identifies a targeted sample of HHAs that are at risk of providing poor quality of care. CMS suggests that including an algorithm of three standard surveys would result in newer HHAs, among others, not being included in the targeting process because these HHAs lack historical survey data. We excluded HHAs that did not meet the study criteria in order to determine clearly the relationship between repeat deficiencies and subsequent survey performance. However, CMS would not need to exclude any HHAs when using an algorithm that makes use of historical data. CMS could modify the algorithm to include any available historical survey data that have been weighted, as appropriate. HHAs with fewer than four surveys included in OSCAR would be assessed based on the survey data that are available. Our analysis demonstrates that historical data can improve CMS's ability to identify at-risk HHAs. CMS should use all available data to target those HHAs most at risk of providing poor quality of care.

As an alternative to modifying the algorithm to include historical survey data, CMS could conduct analysis similar to that described in this report to identify HHAs with repeated deficiencies across multiple surveys. CMS could provide this information to State survey agencies annually to help surveyors identify HHAs that may be in need of closer review, whether or not they appear in the targeted sample.

CMS concurred with the recommendation to implement intermediate sanctions as directed by the OBRA 1987. The agency indicated that changes in law and other regulations, together with the demands of additional improvement efforts, have impeded promulgation of the final rule. CMS outlined several initiatives it has undertaken during this time to address HHA performance and compliance.

CMS also indicated that one finding not addressed in detail in the recommendations may prove useful in targeting HHAs. CMS may rely on information that cyclical deficient HHAs are concentrated in six States to assist them in targeting future surveys.

We revised our description of HHAs' statutorily required survey frequency to address CMS's technical comments.

The text of CMS's comments is available in Appendix F.

Medicare HHA Conditions of Participation and Standards

* Conditions reviewed in all home health agency certification and recertification surveys. CMS State Operations Manual, Pub. No. 100-07, ch. 2, § 2196.1A (rev. 1, May 21, 2004).

** This is a general description of the standard because a title for the standard is not provided.

Administration

42 CFR § 484.10 Condition of Participation: Patient Rights *

(a) Standard: Notice of Rights

(b) Standard: Exercise of Rights and Respect for Property and Person

(c) Standard: Right to be Informed and to Participate in Planning Care and Treatment

(d) Standard: Confidentiality of Medical Records

(e) Standard: Patient Liability for Payment

(f) Standard: Home Health Hotline

42 CFR § 484.11 Condition of Participation: Release of Patient Identifiable Outcome and Assessment Information Set (OASIS) Information *

42 CFR § 484.12 Condition of Participation: Compliance with Federal, State, and Local Laws, Disclosure and Ownership Information, and Accepted Professional Standards and Principles *

(a) Standard: Compliance with Federal, State, and Local Laws and Regulations

(b) Standard: Disclosure of Ownership and Management Information

(c) Standard: Compliance with Accepted Professional Standards and Principles

42 CFR § 484.14 Condition of Participation: Organization, Services, and Administration

(a) Standard: Services Furnished

(b) Standard: Governing Body

(c) Standard: Administrator

(d) Standard: Supervising Physician or Registered Nurse

(e) Standard: Personnel Policies

(f) Standard: Personnel Under Hourly or Per Visit Contracts

(g) Standard: Coordination of Patient Services *

(h) Standard: Services Under Arrangement

(i) Standard: Institutional Planning

(i)(1) Standard: Annual Operating Budget

(i)(2) Standard: Capital Expenditure Plan

(i)(3) Standard: Preparation of Plan and Budget

(i)(4) Standard: Annual Review of Plan and Budget

(j) Standard: Laboratory Services

42 CFR § 484.16 Condition of Participation: Group of Professional Personnel

(a) Standard: Advisory and Evaluation Function

42 CFR § 484.18 Condition of Participation: Acceptance of Patients, Plan of Care, and Medical Supervision *

(a) Standard: Plan of Care

(b) Standard: Periodic Review of Plan of Care

(c) Standard: Conformance with Physician Orders

42 CFR § 484.20 Condition of Participation: Reporting OASIS Information

(a) Standard: Encoding OASIS Data

(b) Standard: Accuracy of Encoded OASIS Data

(c) Standard: Transmittal of OASIS Data

(d) Standard: Data Format

Furnishing of Services

42 CFR § 484.30 Condition of Participation: Skilled Nursing Services

(a) Standard: Duties of the Registered Nurse

(b) Standard: Duties of the Licensed Practical Nurse

42 CFR § 484.32 Condition of Participation: Therapy Services

(a) Standard: Supervision of Physical Therapy Assistant and Occupational Therapy Assistant

(b) Standard: Supervision of Speech Therapy Services

42 CFR § 484.34 Condition of Participation: Medical Social Services

42 CFR § 484.36 Condition of Participation: Home Health Aide Services *

- (a) Standard: Home Health Aide Training
  - (a)(1) Standard: Content and Duration of Training
  - (a)(2) Standard: Conduct of Training
  - (a)(3) Standard: Documentation of Training
- (b) Standard: Competency Evaluation and In-Service Training
  - (b)(1) Standard: Applicability
  - (b)(2) Standard: Content and Frequency of Evaluations and Amount of In-Service Training
  - (b)(3) Standard: Conduct of Evaluation and Training
  - (b)(4) Standard: Competency Determination
  - (b)(5) Standard: Documentation of Competency Evaluation
  - (b)(6) Standard: Effective Date
- (c) Standard: Assignment and Duties of the Home Health Aide
  - (c)(1) Standard: Assignment
  - (c)(2) Standard: Duties
- (d) Standard: Supervision
  - (d)(1) Standard: Supervisory Visit **
  - (d)(2) Standard: On-site Visit for Patients Receiving Skilled Nursing Care **
  - (d)(3) Standard: On-site Visit for Patients Not Receiving Skilled Nursing or Rehabilitation Therapy Services **
  - (d)(4) Standard: Home Health Aide Services Not Provided by an Employee of the Agency **
    - (d)(4)(i) Standard: Ensuring Overall Quality of Care Provided by Aide **
    - (d)(4)(ii) Standard: Supervision of Aide's Services **
    - (d)(4)(iii) Standard: Ensuring Home Health Aides Meet Training Requirements **
- (e) Standard: Personal Care Attendant: Evaluation Requirements

42 CFR § 484.38 Condition of Participation: Qualifying to Furnish Outpatient Physical Therapy or Speech Pathology Services

42 CFR § 484.48 Condition of Participation: Clinical Records *

(a) Standard: Retention of Records

(b) Standard: Protection of Records

42 CFR § 484.52 Condition of Participation: Evaluation of the Agency's Program

(a) Standard: Policy and Administrative Review

(b) Standard: Clinical Record Review

42 CFR § 484.55 Condition of Participation: Comprehensive Assessment of Patients *

(a) Standard: Initial Assessment Visit

(a)(1) Standard: Determine Immediate Care and Support and Medicare Eligibility **

(a)(2) Standard: Visit by Rehabilitation Skilled Professional **

(b) Standard: Completion of the Comprehensive Assessment

(c) Standard: Drug Regimen Review

(d) Standard: Update of the Comprehensive Assessment

(e) Standard: Incorporation of OASIS Data Items

HHA Survey Cycles Prior to Fiscal Year 2006

Prior to fiscal year 2006, the Centers for Medicare & Medicaid Services (CMS) assigned home health agencies (HHA) a survey frequency based on their most recent survey performance.[38] Surveyors generally conducted unannounced recertification surveys every 12 to 36 months based on their Medicare enrollment and survey history.[39] In addition to conducting routine surveys, State agencies annually selected a 5-percent random sample of HHAs on the 36-month survey cycle. This random sample of HHAs received a recertification survey within 16 to 20 months following its last recertification survey.[40]

If an HHA was not out of compliance with any Conditions of Participation (CoP) during the first 3 years after the HHA opened or changed ownership, then the HHA was placed on a 36-month recertification survey cycle. An HHA remained on a 36-month recertification survey cycle if (1) no condition-level deficiencies were out of compliance in any of the previous three recertification surveys; (2) no standard-level deficiencies were cited under the acceptance of patients, plan of care, and medical supervision condition (42 CFR § 484.18) or the comprehensive assessment of patients condition (42 CFR § 484.55) in the previous survey; and (3) no complaints resulted in deficiency citations since the previous survey.[41]

An HHA that failed to meet at least one of the CoP was considered to be providing substandard care and required more scrutiny. If the HHA came back into compliance, it received a survey within 4 to 6 months from the date compliance was established.[42] If the HHA maintained compliance, then it was placed on a 12-month survey cycle until the HHA received no condition-level deficiency citations for at least 2 consecutive years.

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[38] CMS "State Operations Manual," Pub. No. 100-07, ch. 2, § 2195 (rev. 1, May 21, 2004).

[39] Beginning in 1999, the time between surveys for most HHAs increased from a range of 9 to 15 months up to 36 months.

[40] CMS "State Operations Manual," Pub. No. 100-07, ch. 2, § 2195.E (rev. 1, May 21, 2004).

[41] CMS "State Operations Manual," Pub. No. 100-07, ch. 2, § 2195.A (rev. 1, May 21, 2004).

[42] CMS "State Operations Manual," Pub. No. 100-07, ch. 2, § 2195.D (rev. 1, May 21, 2004).

CMS's Algorithm To Identify Targeted Sample of At-Risk HHAs

To produce the 5-percent targeted sample, the Centers for Medicare & Medicaid Services (CMS) now applies an algorithm that identifies at-risk home health agencies (HHA) in each State. For each active HHA that is not due for a 36-month survey, the algorithm assigns a survey priority score that is comprised of the following six data elements:

1. Total number of standard-level deficiencies for the HHA on the most recent survey;
2. Total number of condition-level deficiencies for the HHA on the most recent survey;
3. Total number of standard-level deficiencies on the most recent survey common to closed/terminated HHAs;
4. Total number of risk-adjusted quality improvement outcomes (e.g., improvement in upper body dressing) less than a calculated threshold value as determined by CMS;
5. Total number of non-risk-adjusted quality improvement outcomes (e.g., improvement in cognitive function) less than a calculated threshold value as determined by CMS; and
6. Total number of adverse events deemed "worse" than a calculated threshold value as determined by CMS.[43]

The algorithm generates a score that CMS uses to identify HHAs that are at risk of providing poor quality of care. At the beginning of each fiscal year, CMS shares a targeted list with each State agency that is comprised of the 10 percent of HHAs that have the highest (i.e., worst) scores in the State. Using CMS's targeted list, State agencies then apply their additional knowledge of the HHAs to select the final 5-percent targeted sample for survey.[44] The 36-month survey clock will be reset for HHAs selected for the targeted sample.

[43] University of Colorado at Denver and Health Sciences Center, "Improving Protocols for Home Health Agency Assessment in the Survey Process, Appendix E: Survey Priority Score Algorithm," June 2006.

[44] Quality Assurance for the Medicare & Medicaid Programs: FY 2006 Mission & Priority Document, CMS, Survey and Certification Group, Center for Medicaid and State Operations, p. 11, August 2005.

A P P E N D I X ~ D

Standard-Level Deficiency Citations That Account for Half of All Deficiencies Across the Three Most Recent Surveys for Cyclically Deficient HHAs (n=873)	
Deficiency Citation (G tag)*	**Percentage of Deficiency Citations for Cyclically Deficient HHAs**
1. Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. (G158)	7.5%
2. The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatment, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. (G159)	6.0%
3. A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary. (G236)	5.5%
4. The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. (G337)	3.6%
5. Agency professional staff promptly alerts the physician to any changes that suggest a need to alter the plan of care. (G164)	3.5%
6. The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an onsite visit to the patient's home no less frequently than every 2 weeks. (G229)	2.9%
7. Drugs and treatments are administered by agency staff only as ordered by the physician with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per agency policy developed in consultation with a physician, and after an assessment of considerations. (G165)	2.7%
8. All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. (G143)	2.7%
9. A written summary report for each patient is sent to the attending physician at least every 60 days. (G145)	2.5%
10. Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section. (G224)	2.2%
11. The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur. (G144)	2.1%
12. The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in a home health agency. (G121)	2.0%
13. The registered nurse makes the initial evaluation visit and regularly reevaluates the patient's nursing needs. (G172)	2.0%
14. The HHA furnishes skilled nursing services by or under the supervision of a registered nurse and in accordance with the plan of care. (G170)	1.9%
15. The registered nurse prepares clinical and progress notes, coordinates services, and informs the physician and other personnel of changes in the patient's condition and needs. (G176)	1.9%
16. If a physician refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modifications to the original plan. (G160)	1.5%
Total	**50.5%**

Source: Office of Inspector General analysis of the Centers for Medicare & Medicaid Services survey data, 2007.

* Each standard and condition is affiliated with a specific G tag (e.g., G158). CMS uses G tags to identify deficiencies on the Statement of Deficiencies and Plan of Correction form.

APPENDIX ~ E

Metropolitan Statistical Areas With High Numbers of Cyclically Deficient HHAs				
State	**Metropolitan Statistical Area**	**Number of HHAs With at Least One Citation in Each of Last Three Surveys**	**Number of HHAs With Repeat Citations**	**Percentage of HHAs With Repeat Citations**
CALIFORNIA	Los Angeles-Long Beach-Santa Ana	46	31	67%
	Riverside-San Bernardino-Ontario	27	12	44%
	San Diego-Carlsbad-San Marcos	19	18	95%
	Rest of CA	43	19	44%
	State Total	**135**	**80**	**59%**
FLORIDA	Cape Coral-Fort Meyers	14	6	43%
	Miami-Fort Lauderdale-Miami Beach	140	15	11%
	Rest of Florida	238	17	7%
	State Total	**392**	**38**	**10%**
ILLINOIS	Chicago-Naperville-Joliet	139	117	84%
	Rest of Illinois	113	42	37%
	State Total	**252**	**159**	**63%**
IOWA	Cedar Rapids	11	4	36%
	Des Moines-West Des Moines	4	3	75%
	Waterloo-Cedar Falls	15	3	20%
	Rest of Iowa	145	49	34%
	State Total	**175**	**59**	**34%**
MICHIGAN	Detroit-Warren-Livonia	51	31	61%
	Rest of Michigan	54	32	59%
	State Total	**105**	**63**	**60%**
TEXAS	Dallas-Fort Worth-Arlington	132	38	29%
	Houston-Sugar Land-Baytown	124	21	17%
	McAllen-Edinburg-Mission	29	11	38%
	San Antonio	68	30	44%
	Rest of Texas	384	57	15%
	State Total	**737**	**157**	**21%**

Source: Office of Inspector General analysis of the Centers for Medicare & Medicaid Services survey data, 2007.

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Office of the Administrator
Washington, DC 20201

RECEIVED
2008 JUN -6 PM 3:06
OFFICE OF INSPECTOR GENERAL

DATE: JUN 0 5 2008

TO: Daniel R. Levinson
Inspector General

FROM: Kerry Weems
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Deficiency History and Recertification of Medicare Home Health Agencies" (OEI-09-06-00040)

Thank you for the opportunity to review and comment on the above-referenced draft report from the OIG. The Centers for Medicare & Medicaid Services (CMS) appreciates the contributions and valuable input by the OIG in reviewing the certification and oversight of Medicare home health agencies (HHAs). The purpose of this report was to assess: (1) the extent to which Medicare HHAs repeated the same deficiency across three consecutive surveys; and (2) whether CMS uses deficiency history in its oversight of HHAs.

During the last several years, CMS implemented many improvements to the oversight of HHAs, many of which also address cyclical non-compliance in HHAs. Examples include:

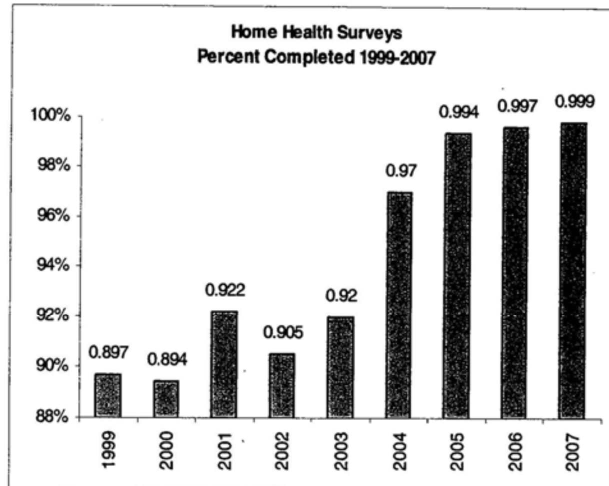
Oversight of Branch Locations: Beginning in August 2002, we began issuance of individual identifiers for each HHA branch. Specific information related to the care provided to patients by these branches is examined as a part of the survey.

Outcome and Assessment Information Set (OASIS) Reports: We enhanced the survey process by adding new reports to the OASIS. Surveyors now review OASIS reports for patients at the HHA before conducting a survey in order to determine specific areas to examine during the survey for HHA branches as well as the HHA overall.

Increased Training: We revised surveyor training to provide more tools for surveyors to use and to improve consistency in survey findings across the Nation. We also provided annual briefings to HHA provider organizations. The briefing includes a listing of the top 10 deficiency citations.

Page 2- Daniel R. Levinson

Targeted Sample: Beginning in 2006, we required States to survey a targeted 5 percent sample of HHAs selected from a CMS list that identifies those agencies for which certain quality indicators suggest a need for greater oversight.



State Performance Improvement: Beginning in fiscal year (FY) 2002 CMS implemented a State Performance Standards System (SPSS). We have strengthened the SPSS each year since. Beginning with FY 2005 performance, we began to connect survey performance with budget allocations. Failure to conduct all statutorily-required surveys resulted in fiscal consequences. As depicted in this graph, the SPSS and CMS' stronger enforcement policy was instrumental in raising the percentage of statutorily-required surveys from 90.5 percent in 2002 to 99.9 percent in 2007.

As discussed below, we have also taken action over the past several years that more specifically addresses the two OIG recommendations.

OIG Recommendation

Use existing survey data to identify patterns of deficiency citations and at-risk HHAs. CMS should also require surveyors to review all available survey data prior to each upcoming survey. In addition, CMS should include multiple survey results in the algorithm that identifies the targeted sample of HHAs that are at risk of providing poor quality of care.

CMS Response

Section 2200A (Task 1- Pre-Survey Preparation) of the State Operations Manual (SOM) requires surveyors to review complaint data, previous survey data, and reports generated by the OASIS system as part of the process of preparing to conduct an onsite survey. The CMS will issue the final version of the OIG report to our Regional Offices and State Survey Agencies, and we will call attention to Section 2200A of the SOM to reinforce the necessity of the review of previous survey data. We concur with this part of the recommendation.

Page 3- Daniel R. Levinson

We do not concur with the recommendation that we include multiple survey results in the algorithm that identifies the targeted sample of HHAs that are at risk of providing poor quality of care. The purpose of the targeting is to direct scarce public dollars to those areas and agencies where greater oversight is most needed. The current algorithm calculates a score for generating the targeted survey sample based on data from a variety of sources, including the OASIS and Online Survey Certification and Reporting data set. The algorithm was developed through a contract with the University of Colorado that examined many possible factors. Since standard HHA surveys are conducted only once every 3 years, an algorithm of three standard surveys would encompass 9-10 years. Many HHAs, particularly newer ones, thus would not be considered in the targeting process and the targeting would often be quite dated. The OIG, for example, found it necessary to exclude from its study 3,655 of the 8,666 active Medicare-certified HHAs because they did not meet the OIG's multi-survey criteria.[1] For these and other reasons the current CMS algorithm uses the most recent survey together with other recent quality indicators. Factoring in more dated historical surveys would lessen the impact of the more recent data.

However, we appreciate the value that OIG is placing on targeted surveys and will continue efforts to improve the effectiveness of such surveys. The OIG report also makes a number of other useful observations that were not converted into recommendations but that merit future consideration. For example, the OIG observes that about 64 percent of the cyclically noncompliant HHAs are located in just six States, and more than 50 percent are located in just three States. We consider this to be an important observation that may assist in future targeting of surveys.

OIG Recommendation

Implement intermediate sanctions as directed by the OBRA 1987.

CMS Response

We concur. While CMS has initiated the rule-making process numerous times, changes in law and other regulations, together with the demands of additional improvement efforts, have unfortunately impeded promulgation of a rule in final form. CMS did publish a Notice of Proposed Rule-Making (NPRM) in 1991 for alternative sanctions. CMS then revised the regulation in response to the comments received. When the legal requirements for HHAs were changed in the Social Security Act in early 1996, CMS determined that the draft alternative sanctions regulation needed substantial revisions. During this time, CMS also developed and released the comprehensive assessment tool for patients served by HHAs, called OASIS. OASIS was successfully moved through demonstration phase, proposed regulation, training to more than 8,000 HHAs, and final rule-making. As significant changes occurred in the home health industry, CMS determined that a comprehensive revision of the HHA Conditions of Participation (CoPs) was needed, and that the issuance of an alternative sanctions rule should be coordinated with those CoP revisions. The revised CoPs were issued as an NPRM in 1997, but have

[1] Draft report, page 7

Page 4- Daniel R. Levinson

not yet been issued as a final rule. In addition, due to egregious and suspicious HHA billing practices, CMS at the same time mobilized cross-component teams addressing HHA fraud and abuse through the Operation Restore Trust (ORT) Initiative. Part of ORT included a moratorium on the enrollment of new HHAs into the Medicare program. CMS' dependence on the same staff for expertise to participate and manage these varied efforts certainly factored into delays in implementing alternative sanctions for HHAs, along with the passage of section 902 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 that required CMS to establish and publish timelines for regulations no later than 3 years after publication of the preceding proposed regulation.

We appreciate the OIG's reminder that rule-making for alternative sanctions for HHAs remains unfinished. Although CMS' unified agenda for rule-making is quite ambitious in the current and coming year, we will continue our efforts to accomplish this objective.

Once again, CMS thanks the OIG for the opportunity to review and comment on this report.

Attachment

ACKNOWLEDGMENTS

This report was prepared under the direction of Timothy S. Brady, Regional Inspector General for Evaluation and Inspections in the San Francisco regional office, and Deborah W. Harvey, Deputy Regional Inspector General.

China Tantameng and Camille Harper were coleaders for this study. Other Office of Evaluation and Inspections staff from the San Francisco regional office who contributed include Scott Hutchison; central office staff who contributed include Rob Gibbons and Sandy Khoury.