

GAO

Report to the Ranking Minority
Member, Committee on Finance, U.S.
Senate

March 2007

NURSING HOMES

Efforts to Strengthen Federal Enforcement Have Not Deterred Some Homes from Repeatedly Harming Residents





Highlights of [GAO-07-241](#), a report to the Ranking Minority Member, Committee on Finance, U.S. Senate

Why GAO Did This Study

In 1998 and 1999 reports, GAO concluded that enforcement actions, known as sanctions, were ineffective in encouraging nursing homes to maintain compliance with federal quality requirements: sanctions were often rescinded before being implemented because homes had a grace period to correct deficiencies. In response, the Centers for Medicare & Medicaid Services (CMS) began requiring immediate sanctions for homes that repeatedly harmed residents. Using CMS enforcement and deficiency data, GAO (1) analyzed federal sanctions from fiscal years 2000 through 2005 against 63 homes previously reviewed and (2) assessed CMS's overall management of enforcement. The 63 homes had a history of harming residents and were located in 4 states that account for about 22 percent of homes nationwide.

What GAO Recommends

GAO recommends that the CMS Administrator (1) develop an administrative process for collecting civil money penalties more expeditiously and seek legislation to implement this process effectively, as appropriate; (2) strengthen its immediate sanctions policy; (3) expand its oversight of homes with a history of harming residents; and (4) improve the effectiveness of its enforcement data systems. CMS generally concurred with GAO's recommendations.

www.gao.gov/cgi-bin/getrpt?GAO-07-241.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Kathryn G. Allen at (202) 512-7118 or allenk@gao.gov.

NURSING HOMES

Efforts to Strengthen Federal Enforcement Have Not Deterred Some Homes from Repeatedly Harming Residents

What GAO Found

From fiscal years 2000 through 2005, the number of sanctions decreased for the 63 nursing homes GAO reviewed that had a history of serious quality problems, a decline consistent with nationwide trends. While the decline may reflect improved quality or changes to enforcement policy, it may also mask survey weaknesses that understate quality problems, an issue GAO has reported on since 1998. Although the number of sanctions decreased, the homes generally were cited for more deficiencies that caused harm to residents than other homes in their states. Almost half of the homes reviewed continued to cycle in and out of compliance; 19 did so 4 times or more. These homes temporarily corrected deficiencies and, even with sanctions, were again found out of compliance on subsequent surveys. Several weaknesses appeared to undermine the effectiveness of the sanctions implemented against the homes reviewed. First, civil money penalties (CMP), which by statute are not paid while under appeal—a process that can take years—were generally imposed at the lower end of the allowable dollar range. For example, the median per day CMP ranged from \$350 to \$500, significantly below the maximum of \$3,000 per day. Second, CMS favored the use of sanctions that give homes more time to correct deficiencies, increasing the likelihood that the sanctions would not be implemented. Thus, more than half of the denial of payment for new admissions (DPNA) that CMS imposed were the type that give homes 3 months to correct deficiencies rather than those that only give homes up to 15 days. Third, there was no record of a sanction for about 22 percent of the homes reviewed that met CMS's criteria for immediate sanctions, a problem GAO also identified in 2003; moreover, 60 percent of DPNAs imposed as immediate sanctions were not implemented until 1 to 2 months after citation of the deficiency. Finally, involuntary termination of homes from participating in the Medicare or Medicaid programs was rare because of concerns about access to other nearby homes and resident transfer trauma; 2 of the 63 homes reviewed were involuntarily terminated because of quality problems.

CMS's management of enforcement is hampered by the complexity of its immediate sanctions policy and by its fragmented and incomplete data. Its policy allows some homes with the worst compliance histories to escape immediate sanctions. For example, a home cited with a serious deficiency and that has not yet corrected an earlier serious deficiency is spared an immediate sanction. Such rules may in part explain why the 63 homes reviewed only had 69 instances of immediate sanctions over a 6-year period despite being cited 444 times for deficiencies that harmed residents. Although CMS initiated development of a new enforcement data system 6 years ago, it is fragmented and has incomplete national reporting capabilities. CMS is taking additional steps to improve nursing home enforcement, such as developing guidance to encourage more consistency in CMP amounts, but it is not clear whether and when these initiatives will address the enforcement weaknesses GAO found.

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Abbreviations

ACTS	ASPEN Complaints/Incidents Tracking System
AEM	ASPEN Enforcement Manager
ASPEN	Automated Survey Processing Environment
CMP	civil money penalty
CMPTS	CMP Tracking System
CMS	Centers for Medicare & Medicaid Services
DPNA	denial of payment for new admissions
LTC	Long Term Care Enforcement Tracking System
OBRA 87	Omnibus Budget Reconciliation Act of 1987
OSCAR	On-Line Survey, Certification, and Reporting system
PDQ	Providing Data Quickly
QIO	Quality Improvement Organization

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United States Government Accountability Office
Washington, DC 20548

March 26, 2007

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

Dear Senator Grassley:

The nation's 1.5 million nursing home residents are a highly vulnerable population of elderly and disabled individuals for whom remaining at home is no longer feasible. The federal government plays a key role in ensuring that nursing home residents receive appropriate care by setting quality requirements that nursing homes must meet to participate in the Medicare and Medicaid programs and by contracting with states to routinely inspect homes and conduct complaint investigations.¹ Moreover, to encourage compliance with these requirements, Congress has authorized certain enforcement actions, known as sanctions, including civil money penalties (CMP) or termination from participating in these programs. With the aging of the baby boom generation, the number of individuals needing nursing home care and the associated costs are expected to increase dramatically. Combined Medicare and Medicaid payments for nursing home services were about \$67 billion in 2004, including a federal share of about \$46 billion.²

In 1998 and 1999 reports, we identified significant weaknesses in federal and state activities designed to detect and correct quality problems at nursing homes.³ A key finding was that sanctions imposed on nursing homes, including those that repeatedly harmed residents, often did not

¹Medicare is the federal health care program for elderly and disabled people. Medicare covers up to 100 days of skilled nursing home care following a hospital stay. Medicaid is the joint federal-state health care financing program for certain categories of low-income individuals. Medicaid also pays for long-term care services, including nursing home care.

²Data for 2004 are the most recent available.

³GAO, *California Nursing Homes: Care Problems Persist Despite Federal and State Oversight*, [GAO/HEHS-98-202](#) (Washington, D.C.: July 27, 1998) and *Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards*, [GAO/HEHS-99-46](#) (Washington, D.C.: Mar. 18, 1999). See a list of related GAO products at the end of this report.

take effect. Instead, the sanctions were rescinded prior to their effective dates because homes had a grace period in which they could and often did correct deficiencies. We referred to this phenomenon as a “yo-yo” pattern of compliance because homes cycled in and out of compliance, harming residents while avoiding sanctions. Overall, we concluded that the goal of the enforcement process—to help ensure that homes maintain compliance with federal quality requirements—was not being realized. In response to our recommendations, the Centers for Medicare & Medicaid Services (CMS), the federal agency that manages these two public health care programs, took several steps, including the introduction of an immediate sanctions policy for homes found to repeatedly harm residents and the development of a new data system to improve management of the enforcement process. Under CMS’s immediate sanctions policy, sanctions may be imposed without giving homes an opportunity to correct serious deficiencies that resulted in actual resident harm or put residents at risk of death or serious injury. We also reported that the deterrent effect of CMPs can be hampered by a backlog of appeals, which further delays payment of CMPs; by statute, CMPs are not paid until appealed cases are closed.

You asked us to assess CMS’s progress in improving the enforcement process, particularly for homes with a history of harming residents. In response to your request, we (1) analyzed federal sanctions from fiscal years 2000 through 2005 against 63 homes with a history of harming residents as well as nationwide trends in nursing home sanctions for the same time period, (2) evaluated the extent to which the homes cycled in and out of compliance and the impact of CMS’s immediate sanctions policy, and (3) assessed CMS’s management of enforcement activities. The nursing homes were located in California, Michigan, Pennsylvania, and Texas and their prior compliance and enforcement histories formed the basis for the conclusions in our March 1999 report.⁴ These homes were selected for that report because of their serious or sustained compliance problems prior to 1999 and are not representative of homes in those states or homes nationwide.⁵ The 63 homes we reviewed for this report

⁴See [GAO/HEHS-99-46](#). The 1999 report focused on 74 homes. We excluded 11 of the original 74 homes from our current analysis because they either closed before fiscal year 2000 or closed within 6 months of the beginning of fiscal year 2000 and therefore had few or no deficiencies or sanctions during the period we reviewed. Of the remaining 63 homes, 10 were located in California, 16 in Michigan, 14 in Pennsylvania, and 23 in Texas (see app. I).

⁵Overall, the nursing homes in these four states account for about 22 percent of nursing homes nationwide.

participated in Medicare and Medicaid for at least 6 months during fiscal years 2000 through 2005. Table 1 shows the number of homes that participated by fiscal year. Changes in the number of homes from year to year are a result of homes' closure, termination, or reinstatement of participation. For example, the change from 61 homes in fiscal year 2000 to 59 homes in fiscal year 2001 represents the voluntary closure of 2 homes, the involuntary termination of 1, and the reinstatement of 1, for a net decrease of 2 homes.⁶

Table 1: Number of Nursing Homes Reviewed in 1999 That Were Included in Our Analysis for This Report

1999 report	Current report								Total number of homes with any participation in 2000-2005
	Fiscal year								
	2000	2001	2002	Average 2000-2002	2003	2004	2005	Average 2003-2005	
74	61	59	58	59	58	54	55	56	63

Source: GAO.

Note: Some of the 63 homes only participated in the Medicare and Medicaid programs for a portion of fiscal years 2000 through 2005 because they either closed permanently or closed temporarily and were subsequently reinstated. To be included in our analysis we required such homes to have participated for at least 6 months of the fiscal year.

Our analysis relied primarily on (1) deficiency data from CMS's On-Line Survey, Certification, and Reporting system (OSCAR) and the CMS Providing Data Quickly (PDQ) Web site; (2) sanctions data from its Long Term Care Enforcement Tracking System (LTC) and ASPEN Enforcement Manager (AEM);⁷ and (3) CMP payment information from its CMP Tracking System (CMPTS).⁸ We also examined CMS regional office and state enforcement case files for the nursing homes we reviewed. We analyzed deficiency and sanctions data to identify the number and type of sanctions implemented and their implementation rates; the extent to which homes cycled in and out of compliance; the use of immediate sanctions for homes that repeatedly harmed residents, including their

⁶By state, the number of homes active for at least 6 months in fiscal years 2000 and 2005 did not change in California, decreased by one home in both Michigan and Texas, and decreased by four homes in Pennsylvania (see app. I). The year-to-year changes in the number of providers do not materially affect our findings on enforcement trends.

⁷ASPEN is an abbreviation for Automated Survey Processing Environment.

⁸See appendix I for a more detailed description of our use of these CMS databases.

deterrent effect; the use of termination; and variability in state approaches to enforcement. To identify trends, we compared deficiency and sanctions data across two time periods: fiscal years 2000 through 2002 and fiscal years 2003 through 2005.⁹ We focused our analysis on three types of sanctions—CMPs, denial of payment for new admissions (DPNA), and terminations—which accounted for about 81 percent of all sanctions from fiscal years 2000 through 2005. Although termination was used infrequently—less than 1 percent of all sanctions—we included it in our analysis because it is the most severe sanction, resulting in the loss of Medicare and Medicaid revenue.¹⁰ Based on our assessment of the data from the case file review, we determined that the sanctions data were sufficiently reliable to assess general nationwide trends in implemented sanctions. Because we could not conduct such checks of the data in all 50 states and the District of Columbia, we did not analyze trends across the individual states.¹¹ We also reviewed CMS enforcement policy and guidance and discussed the immediate sanctions policy and data reliability issues with CMS and state officials. Finally, we obtained perspectives from regional office and state officials on the sanctions used for the homes we reviewed. Our findings on sanctions, such as implementation rates and use of the available range of sanctions, against these homes cannot be generalized to all homes in the 4 states or to all nursing homes nationwide. However, we believe that the findings are illustrative of the overall adequacy of federal and state responses to nursing homes with a history of serious noncompliance with federal quality requirements. Appendix I provides a more detailed description of our scope and methodology, including steps taken to ensure the reliability of the data used in this report. We performed our work from January 2005 through January 2007 in accordance with generally accepted government auditing standards.

Results in Brief

For the homes we reviewed in four states, the number of sanctions implemented as well as the number of serious deficiencies cited declined

⁹Our analysis of the implementation rate of sanctions includes a third baseline time period of July 1995 to October 1998, which we previously reported on in 1999. Our current analysis starts with fiscal year 2000, excluding fiscal year 1999, because one of the major enforcement policies we evaluated was modified in 2000.

¹⁰Throughout this report, we use the term “termination” to refer to a home’s closure for cause, also known as involuntary closure. Homes can and do close voluntarily.

¹¹In this report, we use the term “states” to include the 50 states and the District of Columbia.

from fiscal years 2000 through 2005—trends that were also seen nationwide. While the decline may reflect improved quality or changes to enforcement policy, it may also mask survey weaknesses that understate quality problems, an issue we have reported on since 1998. In general, the homes were cited for more deficiencies that caused harm to residents than other homes in their respective states. For example, the homes we reviewed in California had three times as many serious deficiencies as other homes in the state. We also found differences in the implementation rate of various sanctions for the homes we reviewed. Comparing results from the baseline period of July 1995 to October 1998 with the period fiscal years 2003 through 2005, the implementation rate of CMPs increased from 32 percent to 86 percent but declined for DPNAs by about 20 percent. However, the deterrent effect of CMPs was diluted because CMS imposed CMPs at the lower end of the allowable range for the homes we reviewed. For example, the median per day CMP amount imposed for deficiencies that do not cause immediate jeopardy to residents was \$500 in fiscal years 2000 through 2002 and \$350 in fiscal years 2003 through 2005; the allowable range is \$50 to \$3,000 per day. Generally, CMS did not exercise its discretionary authority to impose DPNAs and terminations for the homes; rather, it waited until these sanctions could be imposed on a mandatory basis, allowing the homes more opportunities to escape sanctions prior to implementation. Moreover, in some instances, CMS extended the implementation dates of imposed terminations, thus allowing homes additional time to avoid being terminated by correcting deficiencies.

Despite changes in federal enforcement policy, almost half of the 63 homes we reviewed—homes with prior serious quality problems—continued to cycle in and out of compliance during fiscal years 2000 through 2005, causing harm to residents. These homes corrected deficiencies only temporarily and, despite having had sanctions implemented, were again found to be out of compliance, including 8 homes that cycled in and out of compliance 7 or more times. During this same time period, 27 of the 63 homes were cited 69 times for deficiencies that warranted immediate sanctions, but 15 of these cases did not result in immediate sanctions. Moreover, the “immediate sanctions” label is misleading because CMS’s policy requires only that homes be notified immediately of CMS’s intent to implement sanctions, not that sanctions be implemented immediately. When DPNAs are imposed, the lag time between the occurrence of a deficiency that results in an immediate sanction and the sanction’s implementation date provides a de facto grace period; if the home is able to correct the deficiency, it can escape sanctions. Although the use of CMPs avoids this de facto grace period

because they can be implemented retroactively, by statute, payment of CMPs may be delayed until after exhausting appeals of the underlying deficiency, a process that can take years. Nor did CMS's implementation of immediate sanctions appear to deter future repeat deficiencies—18 of the 27 homes with immediate sanctions had multiple instances of such sanctions in fiscal years 2000 through 2005. Termination of a home from the Medicare and Medicaid programs was infrequent. By the end of fiscal year 2005, only 2 homes were terminated involuntarily because of quality problems. Another 9 that closed did so voluntarily. In effect, these homes picked their own closure dates and may have continued to harm residents before closing. For example, 2 such homes were cited for harming residents 21 and 26 times, respectively, and had sanctions implemented numerous times from fiscal year 2000 until their voluntary closures in 2004.

In general, the effectiveness of CMS's management of nursing home enforcement is hampered by the overall complexity of its immediate sanctions policy, intended to deter repeated noncompliance, and by its fragmented data systems and incomplete national reporting capabilities. First, the complexity of the immediate sanctions policy allows some homes with the worst compliance histories—the very homes the policy was designed to address—to escape immediate sanctions. For example, homes that do not correct deficiencies can avoid immediate sanctions because of the requirement for an intervening period of compliance between the pair of surveys that identify serious deficiencies—that is, a new serious deficiency will not trigger an immediate sanction unless the prior serious deficiency has been corrected. Thus, if a state survey agency cited a home for a serious deficiency and 2 weeks later—before the first deficiency was corrected—cited the home for another serious deficiency, the home might not receive an immediate sanction. In addition, homes—even those with a history of multiple serious deficiencies—may escape immediate sanctions because a routine inspection without such a serious deficiency, in effect, clears the home's record for determining if immediate sanctions are applicable. The immediate sanctions associated with CMS's policy also are often inequitable; multiple serious deficiencies during one inspection may result in the same sanction as an inspection with a single serious deficiency. Second, CMS's fragmented and incomplete data systems continue to hamper its ability to monitor enforcement. We previously reported that CMS lacked a data system that integrated enforcement data nationwide and that the lack of such a system made it difficult for CMS to consistently manage and monitor sanctions across states and its regional offices. Although CMS has developed a new data system, the system's components are not integrated, and the national

reporting capabilities are not complete. Finally, CMS is taking steps to improve its enforcement of nursing home quality requirements. In addition to its new data system, the agency piloted new guidance in 2006 designed to encourage more consistency across states in the amount of CMPs, revised a program that provides enhanced enforcement and monitoring of some homes with a history of harming residents in each state, and funded studies to examine the effectiveness of nursing home enforcement.

We are recommending that, to increase the deterrent effect of CMPs, the Administrator of CMS develop an administrative process to collect CMPs prior to exhaustion of appeals, seek legislation for the implementation of this process, and address any due process concerns, as appropriate. We are also recommending that the CMS Administrator take actions to (1) improve the immediate sanctions policy to help ensure that homes that repeatedly harm residents or place them in immediate jeopardy do not escape immediate sanctions, (2) strengthen the deterrent effect of certain sanctions, (3) expand a program of enhanced enforcement for homes with a history of noncompliance, and (4) improve the effectiveness of the agency's data systems used for enforcement. In commenting on a draft of this report, CMS generally concurred with our recommendations but did not always specify how it would implement them. In addition, CMS noted that implementation of three of our recommendations raised resource issues and that others required additional research. The four states in which the nursing homes we reviewed were located generally concurred with our findings.

Background

Ensuring the quality and safety of nursing home care has been a focus of considerable congressional attention since 1998. Titles XVIII and XIX of the Social Security Act establish minimum requirements in statute that all nursing homes must meet to participate in the Medicare and Medicaid programs, respectively. With the Omnibus Budget Reconciliation Act of 1987 (OBRA 87), Congress focused the requirements on the quality of care actually provided by a home.¹² To help ensure that homes maintained compliance with the new requirements, OBRA 87 also established the range of available sanctions, to include CMPs, DPNAs, and termination.¹³

¹²Pub. L. No. 100-203, §§4201, 4211, 101 Stat. 1330-160, 1330-182.

¹³Pub. L. No. 100-203, §§4203, 4213, 101 Stat. 1330-179, 1330-213.

Ensuring Compliance with Federal Quality Requirements

CMS contracts with state survey agencies to assess whether homes meet federal quality requirements through routine inspections, known as standard surveys,¹⁴ and complaint investigations. The requirements are intended to ensure that residents receive the care needed to protect their health and safety, such as preventing avoidable pressure sores, weight loss, and accidents. While a standard survey involves a comprehensive assessment of federal quality requirements, a complaint investigation generally focuses on a specific allegation regarding resident care or safety; complaints can be lodged by a resident, family member, or nursing home employee. Deficiencies identified during either standard surveys or complaint investigations are classified in 1 of 12 categories according to their scope (i.e., the number of residents potentially or actually affected) and severity. An A-level deficiency is the least serious and is isolated in scope, while an L-level deficiency is the most serious and is considered to be widespread in the nursing home (see table 2).¹⁵ When state surveyors identify and cite B-level or higher deficiencies, the home is required to prepare a plan of correction and, depending on the severity of the deficiency, surveyors conduct revisits to ensure that the home actually implemented its plan and corrected the deficiencies.¹⁶

Table 2: Scope and Severity of Deficiencies Identified during Nursing Home Surveys

Severity	Scope		
	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.

^aActual or potential for death/serious injury.

^bNursing home is considered to be in substantial compliance.

¹⁴Every nursing home receiving Medicare or Medicaid payment must undergo a standard survey not less than once every 15 months, and the statewide average interval for these surveys must not exceed 12 months.

¹⁵Throughout this report, we use the term serious deficiency to refer to care problems at the level of actual harm or immediate jeopardy.

¹⁶State survey teams generally consist of registered nurses, social workers, dietitians, and other specialists.

Homes with deficiencies at the A, B, or C levels are considered to be in substantial compliance with federal quality requirements, while homes with D-level or higher deficiencies are considered noncompliant. A noncompliance period begins when a survey finds noncompliance and ends when the home either achieves substantial compliance by correcting the deficiencies or when the home is terminated from Medicare and Medicaid. Since 1998, the deficiencies cited during standard surveys have been summarized on CMS's Nursing Home Compare Web site, and CMS subsequently added data on the results of complaint investigations.¹⁷ These data are intended to help consumers select a nursing home that takes into account the quality of care provided to residents.

Range of Federal Sanctions

CMS and the states can use a variety of federal sanctions to help encourage compliance with quality requirements ranging from less severe sanctions, such as indicating the specific actions needed to address a deficiency and providing an implementation time frame, to those that can affect a home's revenues and provide financial incentives to return to and maintain compliance (see table 3).¹⁸ Overall, two sanctions—CMPs and DPNAs—accounted for 80 percent of federal sanctions from fiscal years 2000 through 2005.

¹⁷See <http://www.medicare.gov/NHCompare>.

¹⁸In addition to federal sanctions, states may impose their own sanctions under their state licensure authority.

Table 3: Sanctions Available to Encourage Nursing Home Compliance with Requirements

Sanction	Description
CMP	The home pays a fine for each day or instance of noncompliance.
DPNA	Medicare and/or Medicaid payments can be denied for all newly admitted eligible residents. ^a
Directed in-service training	The home is required to provide training to staff on a specific issue identified as a problem in the survey.
Directed plan of correction	The home is required to take action within specified time frames according to a plan of correction developed by CMS, the state, or a temporary manager.
State monitoring	An on-site monitor is placed in the home to help ensure that the home achieves and maintains compliance.
Temporary management	The nursing home accepts a substitute manager appointed by the state with the authority to hire, terminate, and reassign staff; obligate funds; and alter the nursing home's procedures, as appropriate.
Termination	Termination from the Medicare and Medicaid programs. The home is no longer eligible to receive Medicare and Medicaid payments for beneficiaries residing in the home.

Source: CMS.

Notes: Most of the above sanctions are authorized by statute (see 42 U.S.C. §1395i-3(h) and 42 U.S.C. §1396r(h)), while directed in-service training is authorized by regulation (see 42 C.F.R. § 488.406(a)). Additional or alternative sanctions may also be used (see 42 C.F.R. § 488.406(c)).

^aCMS may also deny payment for all Medicare- and/or Medicaid-covered residents but seldom does so because it may severely limit the homes' revenues for patient care.

The majority of federal sanctions implemented from fiscal years 2000 through 2005—about 54 percent—were CMPs. CMPs may be either per day or per instance. CMS regulations specify a per day CMP range from \$50 to \$10,000 for each day a home is noncompliant—from \$50 to \$3,000 for nonimmediate jeopardy and \$3,050 to \$10,000 for immediate jeopardy. The overall amount of the fine increases the longer a home is out of compliance.¹⁹ For example, a home with a per day CMP of \$5,000 that is out of compliance for 10 days would accrue a total penalty of \$50,000. A per day CMP can be assessed retroactively, starting from the first day of noncompliance, even if that date is prior to the date of the survey that identified the deficiency.

¹⁹Federal statutes specify that CMPs may not exceed \$10,000 for each day of noncompliance. 42 U.S.C. §1395i-3(h)(2)(B)(ii) and 42 U.S.C. §1396r(h)(3)(C)(ii).

Per instance CMPs range from \$1,000 to \$10,000 per episode of noncompliance.²⁰ While multiple per instance CMPs can be imposed for deficiencies identified during a survey, the total amount cannot exceed \$10,000. Per day and per instance CMPs cannot be imposed as a result of the same survey, but a per day CMP can be added when a deficiency is identified on a subsequent survey if a per instance CMP was the type of CMP initially imposed. Unlike other sanctions, CMPs require no notice period. However, if a home appeals the deficiency, by statute, payment of the CMP—whether received directly from the home or withheld from the home’s Medicare and Medicaid payments—is deferred until the appeal is resolved.²¹

DPNAs made up about 26 percent of federal sanctions from fiscal years 2000 through 2005. A DPNA denies a home payments for new admissions until deficiencies are corrected. In contrast to CMPs, CMS regulations require that homes be provided a notice period of at least 15 days for other sanctions, including DPNAs; the notice period is shortened to 2 days in the case of immediate jeopardy. As a result, homes can avoid DPNAs if they are able to correct deficiencies during the notice period, which provides a de facto grace period. Unlike CMPs, DPNAs cannot be imposed retroactively, and payment denial is not deferred until appeals are resolved.

Although nursing homes can be terminated involuntarily from participation in Medicare and Medicaid, which can result in a home’s closure, termination is used infrequently.²² Terminations were less than 1 percent of total sanctions from fiscal years 2000 through 2005. Four of the seven types of sanctions described above were used less frequently than CMPs and DPNAs—directed plan of correction, state monitoring, directed in-service training, and temporary management—these sanctions

²⁰Unlike for per day CMPs, CMS does not specify a particular per instance CMP range for cases of immediate jeopardy.

²¹If efforts to collect the CMP directly from the home fail, Medicare and Medicaid payments are withheld.

²²Homes also can choose to close voluntarily, but we do not consider voluntary closure to be a sanction. When a home is terminated, it loses any income from Medicare and Medicaid, which accounted for about 40 percent of nursing home payments in 2004. Residents who receive support through Medicare or Medicaid must be moved to other facilities. However, a terminated home generally can apply for reinstatement if it corrects its deficiencies.

accounted for about 19 percent of sanctions nationwide from 2000 through 2005.

Imposition of Sanctions

The statute permits and, in some cases, requires that DPNA or termination be imposed for homes found out of compliance with federal quality requirements. Mandatory termination and DPNA are required, as follows:

- Termination—Termination is required by regulations under the statute if within 23 days of the end of a survey a home fails to correct immediate jeopardy deficiencies,²³ or within 6 months of the end of a survey the home fails to correct nonimmediate jeopardy deficiencies.
- DPNA—A DPNA is required by statute if within 3 months of the end of a survey a home fails to correct deficiencies and return to compliance or when a home's last three standard surveys reveal substandard quality of care.²⁴

The statute also authorizes CMS to impose discretionary DPNA and discretionary terminations in situations other than those specified above.²⁵ Federal regulations further stipulate that such discretionary sanctions may be implemented as long as a facility is given the appropriate notice period. By regulation, the notice period for implementing both discretionary and mandatory DPNA and terminations is 15 days; in cases of immediate jeopardy, however, the notice period is 2 days.

²³Instead of termination, a temporary manager may be appointed to remove the immediate jeopardy.

²⁴According to CMS, *substandard quality of care* exists when a home is cited for a deficiency at the F, H, I, J, K, or L level in any 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, which can include deficiencies such as a failure to protect residents from abuse. This definition excludes deficiencies at the G level (actual harm). For purposes of this report, we define *serious deficiencies* as G-level or higher deficiencies. The statute allows CMS to deny payment for all residents; however, our analysis focuses on the denial of payment for new admissions, a more frequently used sanction.

²⁵By implementing either a mandatory or discretionary termination, CMS is acting to involuntarily terminate the nursing home.

In imposing sanctions, CMS takes into account four factors: (1) the scope and severity of the deficiency, (2) a home's prior compliance history, (3) desired corrective action and long-term compliance, and (4) the number and severity of all the home's deficiencies. In general, the severity of the sanction increases with the severity of the deficiency. For example, for immediate jeopardy deficiencies (J, K, and L on CMS's scope and severity grid) the regulations require that either or both temporary management or termination be imposed, and also permits use of CMPs of from \$3,050 to \$10,000 per day or \$1,000 to \$10,000 per instance of noncompliance. Similarly, for deficiencies at the actual harm level (G, H, and I on the scope and severity grid) the regulations require one or a combination of the following sanctions: temporary management, a DPNA, a per day CMP of \$50 to \$3,000, or a per instance CMP of \$1,000 to \$10,000 per instance of noncompliance. In addition to these required sanctions, other sanctions can be included; for example, depending on the severity of the deficiency and a home's compliance history, it could have a combination of state monitoring, a DPNA, and a CMP. Finally, CMS is required to consider the immediacy of sanctions. The statute stipulates that sanctions should be designed to minimize the time between the identification of violations and the final imposition of the sanctions.²⁶

State and CMS Roles in Sanctioning Homes

Enforcement of nursing home quality-of-care requirements is a shared federal-state responsibility. In general, sanctions are (1) initially proposed by the state survey agency based on a cited deficiency, (2) reviewed and imposed by CMS regional offices, and (3) implemented—that is, put into effect—by the same CMS regional office, usually after a required notice period (see fig. 1).²⁷ CMS regional offices typically accept state-proposed sanctions but can modify them. The regional office notifies the home by letter that a sanction is being imposed—that is, its intent to implement a sanction—and the date it will be implemented. State surveyors may make follow-up visits to the home to determine whether the deficiencies have been corrected. The CMS regional office implements the sanctions if the deficiencies are not corrected. Homes may appeal the cited deficiency and,

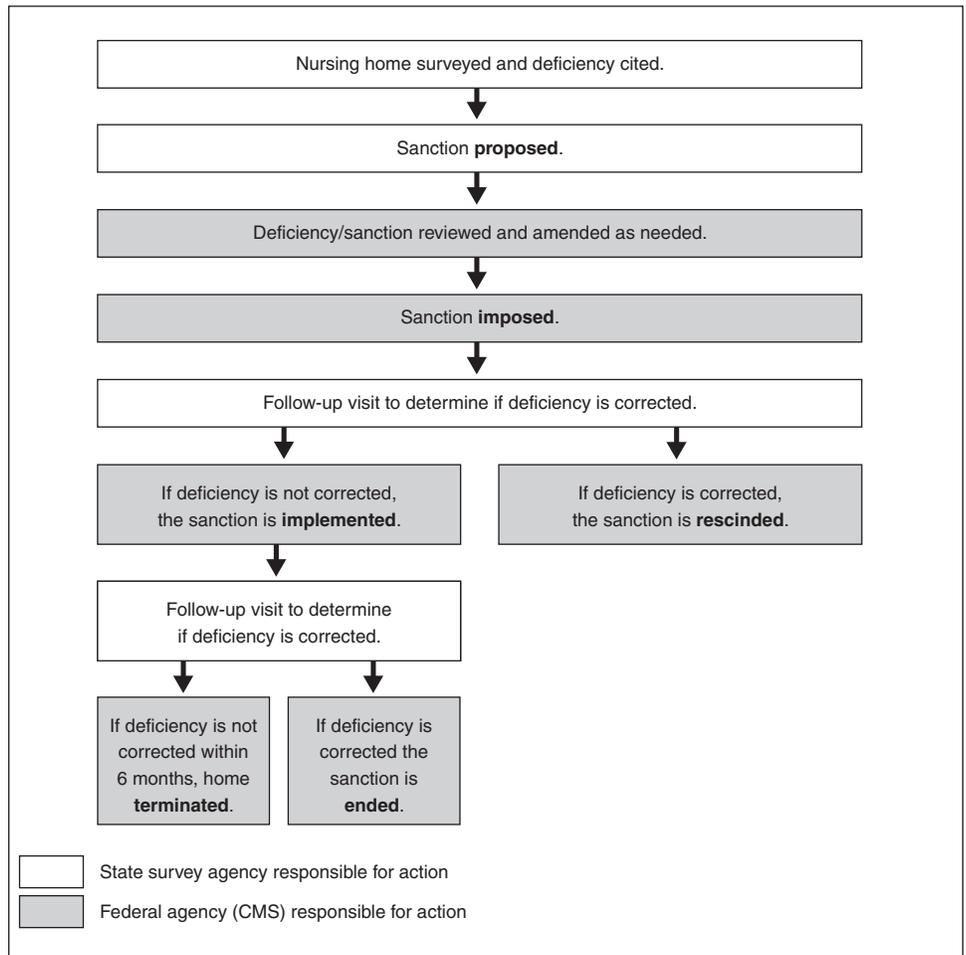
²⁶See 42 U.S.C. § 1395i-3(h)(2)(B) and 42 U.S.C. § 1396r(h)(2)(A).

²⁷While this description applies to the approximately 93 percent of homes that receive either Medicare or both Medicare and Medicaid payments, states are responsible for enforcing standards in the 7 percent of homes that only receive Medicaid payments and may impose certain sanctions, such as state monitoring and DPNAs. Notice periods for most sanctions are required by CMS regulations.

if the appeal is successful, the severity of the sanction could be reduced or the sanction could be rescinded. Homes have several avenues of appeal, including informal dispute resolution at the state survey agency level or a hearing before an administrative law judge, as well as before the Department of Health and Human Services Departmental Appeals Board. Under CMS policy, homes automatically receive a 35 percent reduction in the amount of a CMP if they waive their right to appeal before the Departmental Appeals Board.²⁸

²⁸See 42 C.F.R. § 488.436.

Figure 1: Federal-State Responsibilities in the Enforcement Process



Source: GAO.

Notes: States may impose lower-level sanctions, such as state monitoring, without federal approval. Some state survey agencies also have the ability to impose federal sanctions such as DPNAs. Nursing homes are notified of their appeal rights when CMS imposes a sanction.

CMS Enforcement Initiatives

In response to our earlier recommendations, CMS undertook a number of initiatives intended to strengthen enforcement, many of which we reported on in 2005.²⁹ For example, CMS (1) revised its revisits policy by

²⁹See GAO, *Nursing Homes: Despite Increased Oversight, Challenges Remain in Ensuring High-Quality Care and Resident Safety*, [GAO-06-117](#) (Washington, D.C.: Dec. 28, 2005).

requiring surveyors to return to nursing homes to verify that serious deficiencies had actually been corrected; (2) hired more staff to reduce the backlog of appeals at the Health and Human Services Departmental Appeals Boards, the entity that adjudicates nursing home appeals of deficiency citations; (3) began annual assessments of state survey activities, known as state performance reviews, which cover, among other things, the timeliness of sanction referrals from state survey agencies to CMS regional offices; and (4) revised its past noncompliance policy for citing and reporting serious deficiencies that were missed by state surveyors during earlier surveys of a home.

A key CMS enforcement initiative was the two-stage implementation of an immediate sanctions policy. In the first stage, effective September 1998, CMS required states to refer for immediate sanction homes found to have a pattern of harming or exposing residents to actual harm or potential death or serious injury (H-level or higher deficiencies on the agency's scope and severity grid) on successive surveys.³⁰ Effective January 2000, CMS expanded the policy, requiring referral of homes found to have harmed one or a small number of residents (G-level deficiencies) on successive routine surveys or intervening complaint investigations.³¹ After expansion of the immediate sanctions policy to include G-level deficiencies, it became known as the double G immediate sanctions policy.

CMS also took steps to improve its ability to manage and oversee the enforcement process. Our 1999 report described how CMS regions and states were using their own systems to track sanctions rather than CMS's OSCAR database. Regional office systems ranged from manual, paper-based records to complex computer programs; none of the four states included in our 1999 report had tracking systems compatible with OSCAR or the regional office systems in use. Until it implemented a new

³⁰ Although the policy requires the immediate imposition of sanctions, CMS has not defined a time standard for "immediate." The policy only requires that homes with a pattern of harming residents be denied a grace period to correct deficiencies before the sanctions are imposed. Prior to the policy, homes were given a grace period in which they could correct deficiencies before sanctions were imposed.

³¹ CMS guidance also gives states and regional offices the option to rescind a home's "opportunity to correct" based on (1) scope and severity of the deficiency, (2) unwillingness and inability of the facility to correct the deficiency, and (3) the effectiveness of the facility's quality assurance and monitoring system to prevent recurrence of the deficiency.

enforcement data collection system, CMS used LTC, an interim enforcement tracking system developed and first used by its Chicago regional office. LTC was operational in all 10 regions by January 2000. CMS's enforcement data collection system—AEM—replaced LTC and was implemented 4 years later, on October 4, 2004.

Recognizing the need to focus more attention on homes that historically provided poor care, CMS designed and launched a Special Focus Facility program in January 1999, instructing states to select 2 homes each for enhanced monitoring. Surveys were to be conducted at 6-month intervals rather than annually. In September 2000, CMS reported that semiannual surveys had been conducted at a little more than half of the original 110 facilities. In late 2004, CMS modified the program by (1) expanding its scope to include more homes, (2) revising the selection criteria for homes, and (3) strengthening sanctions for homes that did not improve within 18 months. In a relevant but unrelated initiative, CMS established a voluntary program to help nursing homes improve the quality of care provided to residents. In 2002, Medicare Quality Improvement Organizations (QIO) began working intensively on issues such as preventing pressure sores and pain management with 10 percent to 15 percent of nursing homes in each state.³² Responding to concerns that QIOs were not working with homes that needed the most help, CMS established a separate pilot program in 2004; QIOs worked for 12 months with 1 to 5 nursing homes with significant quality problems in 18 states to help them redesign their clinical practices. Unlike the Special Focus Facility program, the participation of homes in the pilot was voluntary. To distinguish it from the Special Focus Facility program, the pilot was known as the Collaborative Focus Facility program.

Number of Sanctions Has Decreased

Among the homes we reviewed in four states, the number of implemented sanctions and serious deficiencies declined across two time periods—fiscal years 2000 through 2002 and fiscal years 2003 through 2005. Federal data show similar declines for homes nationwide, a trend consistent with the decline in the proportion of homes cited for serious deficiencies that

³²Under contract with CMS, QIOs (formerly known as Peer Review Organizations) working in all 50 states and the District of Columbia help to ensure the quality of care delivered to Medicare beneficiaries. Prior to 2002, QIOs' work focused on care delivered in acute care settings such as hospitals.

generally result in sanctions.³³ Despite the decline in the number of serious deficiencies, the homes we reviewed generally were cited for more deficiencies that caused harm to residents than other homes in the four states. While the numbers of implemented CMPs and DPNAs at the homes we reviewed declined across the two time periods, the amount of CMPs paid increased. Not all imposed sanctions for these homes were implemented, however, which may reduce the deterrent effect of sanctions; in fact, we found that the implementation rate of certain sanctions, such as DPNAs, decreased. The deterrent effect of sanctions for the homes was further eroded because CMS generally imposed CMPs on the lower end of the allowable dollar range and did not exercise its authority to use discretionary DPNAs and terminations, allowing the homes more opportunities to escape sanctions prior to implementation.

Sanctions Have Declined Nationwide

Among all nursing homes nationwide, sanctions declined across the two time periods—fiscal years 2000 through 2002 and fiscal years 2003 through 2005.³⁴ Implemented terminations declined the most across the two time periods (about 41 percent) and CMPs declined the least (about 12 percent), while the number of DPNAs declined by about 31 percent. In the same time periods, the average number of serious deficiencies per home declined by about 33 percent nationwide, from about 0.8 to about 0.5. These downward trends are also consistent with the nationwide decline in the proportion of homes with serious deficiencies—from about 28 percent in fiscal year 2000 to about 17 percent in fiscal year 2005 (see app. II). While the reported decline in serious deficiencies and the proportion of homes cited for such deficiencies may be due to improved quality, our earlier reports noted similar declines that masked (1) understatement of serious quality problems, and (2) inconsistency in how states conduct surveys.³⁵ For example, our current analysis found that the proportion of homes cited for serious deficiencies ranged from a low of about 4 percent in Florida to a high of about 44 percent in Connecticut

³³While the reported decline in the proportion of homes with serious deficiencies could be due to improved quality, we have also documented the underreporting of serious deficiencies. See GAO, *Nursing Home Quality: Prevalence of Serious Problems, While Declining, Reinforces Importance of Enhanced Oversight*, GAO-03-561 (Washington, D.C.: July 15, 2003) and GAO-06-117.

³⁴Although sanctions declined during the period we reviewed, they nearly doubled from fiscal years 1999 to 2000.

³⁵See GAO/HEHS-98-202, GAO-03-561, or GAO-06-117.

during fiscal year 2005.³⁶ Across the four states we reviewed, the proportion of homes with serious deficiencies in fiscal year 2005 ranged from 8 percent in California to 23 percent in Michigan. As we previously reported, such disparities are more likely to reflect inconsistency in how states conduct surveys rather than actual differences in the quality of care provided by homes.³⁷ In addition, in commenting on a draft of this report, CMS noted concerns about whether the immediate sanctions policy has had a negative effect on state citations of serious deficiencies.

Decline in Sanctions and Deficiencies for the Homes Reviewed Is Consistent with Nationwide Trends

The number of implemented sanctions at the homes we reviewed as well as the number of serious deficiencies cited in these homes declined across two time periods—fiscal years 2000 through 2002 and fiscal years 2003 through 2005—consistent with nationwide trends.

Deficiency trends. The average number of serious deficiencies per home we reviewed decreased from about 1.8 in fiscal years 2000 through 2002 to about 0.7 in fiscal years 2003 through 2005, about a 61 percent decline; this decline was consistent with the national trend. During both time periods, however, the homes we reviewed generally performed more poorly than other homes in their states, having, on average, more G-level or higher deficiencies and more double Gs. For example, the Texas homes we reviewed had on average 1.3 times as many G-level or higher deficiencies as all other homes in the state and the California homes we reviewed had on average 3 times as many as all other California nursing homes.³⁸

CMP trends. Due in part to the closure of some poorly performing homes and the citation of fewer serious deficiencies, the homes we reviewed had

³⁶This analysis excluded 13 states because fewer than 100 homes were surveyed, and even a small increase or decrease in the number of homes with serious deficiencies in such states may produce a relatively large percentage point change.

³⁷CMS acknowledges that there is inconsistency in how states conduct surveys and is trying to address this issue by piloting a revised survey methodology. In commenting on a draft of this report, California noted that until late 2004 its CMS regional office required evidence of permanent harm in order for a deficiency to be cited as actual harm. After California received new guidance on the definition of actual harm, we noted that the number of determinations of harm increased.

³⁸Despite the poor performance histories of some of the 63 homes, only 1 of these homes was part of CMS's original Special Focus Facilities program. In 2005, only 2 of the homes we reviewed were designated Special Focus Facilities and in 2006, only 4 were so designated.

fewer CMPs in fiscal years 2003 through 2005 than in the prior 3 fiscal years, but the amount paid was higher (see table 4). Among the homes, the number of implemented CMPs declined by about 42 percent from the first to the second time period. Although the number of CMPs among the homes we reviewed decreased, the amount of CMPs paid in Michigan more than doubled between the two time periods, accounting for much of the increase in the amount of CMPs paid across the two time periods (see app. III). States' preferences for either state or federal CMPs may in part affect their use. In Michigan, state officials are more likely to use federal CMPs and implement them in greater amounts than other states we reviewed. In contrast, the homes we reviewed in Pennsylvania had only one implemented CMP and paid no federal CMPs from fiscal years 2003 through 2005; however, during the same period, the Pennsylvania state survey agency implemented seven state CMPs and collected \$12,050.³⁹ A Pennsylvania state survey agency official said that the state prefers to use state sanctions because they can be implemented more quickly and are believed to be more effective than federal sanctions. The Texas state survey agency does not recommend more than one type of money penalty for the same deficiency and chooses among one of two state money penalties or a federal CMP.⁴⁰

³⁹In addition to federal sanctions, states can impose state sanctions on noncompliant homes. The revenue from state CMPs accrues to the state but must be applied to the protection of the health or property of nursing home residents.

⁴⁰According to Texas officials, this money penalty policy took effect on September 1, 2003, as a result of a state statutory change. Prior to the statutory change, the state survey agency could recommend both a state money penalty as well as a federal CMP.

Table 4: Sanctions Implemented for Homes Reviewed, Fiscal Years 2000-2002 and 2003-2005

Sanction	Fiscal years 2000-2002		Fiscal years 2003-2005		Percentage change in number between two time periods
	Number	Duration/ amount paid	Number	Duration/ amount paid	
CMP ^{a,b}	93	\$534,527	54	\$617,552	-42%
DPNA ^c	52	2,451 days	30	1,245 days	-42%
Involuntary termination	1	NA	1	NA	0%

Source: GAO analysis of LTC data, AEM, CMS regional office and state enforcement case files, and CMPTS.

Note: Includes homes that were open for at least part of the 6-year period.

NA = Not applicable.

^aIncludes per day and per instance CMPs.

^bAmount paid for CMPs implemented in these fiscal years.

^cIncludes mandatory and discretionary DPNAs.

DPNA trends. The number of DPNAs declined by 42 percent from fiscal years 2000 through 2002 to fiscal years 2003 through 2005 for the homes we reviewed. Overall, the duration of the DPNAs decreased by 12 percent from the first to the second time period. The duration of DPNAs among the Texas homes we reviewed decreased the most—from an average of 46 days in the first time period to an average of 26 days in the second time period. The duration of DPNAs among the Michigan and Pennsylvania homes also decreased (see app. III). In California, however, the DPNAs were in effect longer in the second time period—from an average of 39 days in fiscal years 2000 through 2002 to an average of 63 days in fiscal years 2003 through 2005. As a result, homes in California were out of compliance for longer periods of time.

Termination trends. Only two of the homes we reviewed closed involuntarily—that is, they were terminated for cause by CMS because of health and safety issues. One of the two homes has since been certified to participate in Medicare again.⁴¹ An additional nine other homes closed voluntarily, although four reopened at some point during fiscal years 2000

⁴¹This home is located in Texas, where the state issues a license to the person or entity operating the nursing home rather than the owner of the real property. The majority of nursing homes in Texas are operated out of leased property. When the home was recertified, the new operator was licensed; there was no change in the owner of the real property.

through 2005.⁴² However, a home's voluntary closure may not accurately reflect the degree to which the home had quality problems, such as a history of harming residents, that put the home at risk of involuntary termination. The reasons for closure, as recorded by CMS, are general and do not always reflect that homes may have histories of harming residents and may have been at risk of involuntary termination.

Implementation Rate of Some Sanctions Has Declined for the Homes Reviewed

The implementation rate of DPNAs and terminations declined for the homes we reviewed, while the implementation rate of CMPs increased across three time periods (see fig. 2). Some sanctions are never implemented because CMS rescinds them if homes correct deficiencies before the implementation date, a situation we noted in our 1999 report.⁴³ Thus, sanctions may be considered more of a threat than a real consequence of noncompliance.

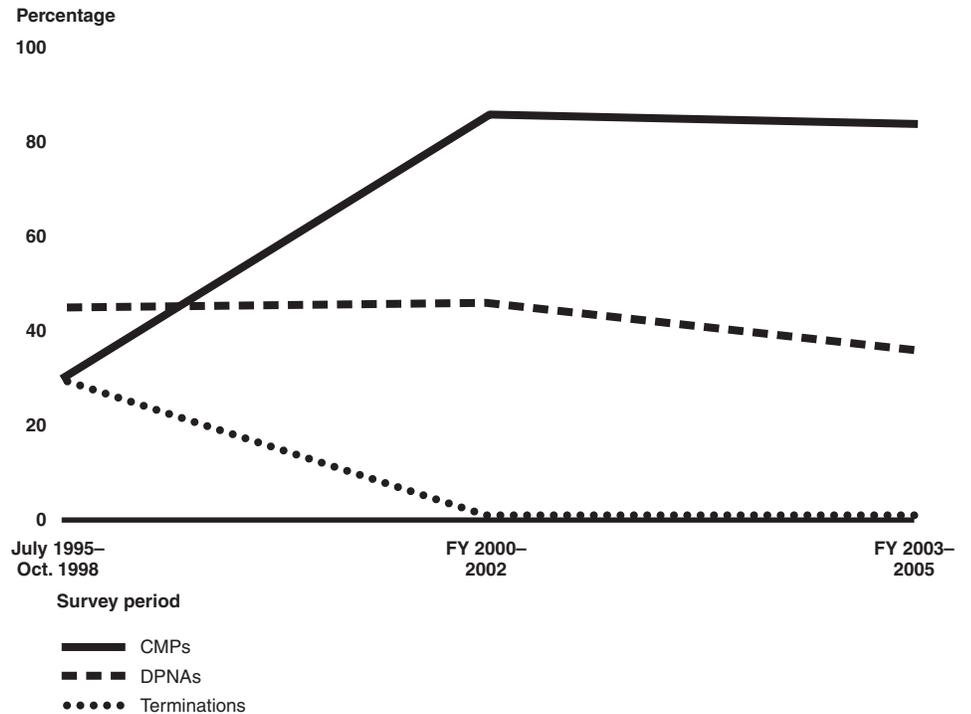
We compared the implementation rates of CMPs, DPNAs, and terminations across three time periods: (1) July 1995 to October 1998, the time period covered in our March 1999 report;⁴⁴ (2) fiscal years 2000 through 2002; and (3) fiscal years 2003 through 2005. From the first time period to the third, the implementation rate for DPNAs declined by about 20 percent and the implementation rate for terminations declined by about 97 percent. In contrast, across the same time periods, the overall implementation rate for CMPs increased from 32 percent in the first time period to 86 percent in the third time period, an almost threefold increase. The timing of this increase coincides with the January 2000 implementation of the immediate sanctions policy, suggesting that the increase may in part be related to the policy's implementation.

⁴²Although the homes were closed for some part of the period we reviewed, fiscal years 2000 through 2005, we determined that there were sufficient data to include the homes in our sample.

⁴³[GAO/HEHS-99-46](#).

⁴⁴[GAO/HEHS-99-46](#).

Figure 2: Percentage of Implemented Sanctions for Homes Reviewed Over Three Time Periods (July 1995-October 1998, Fiscal Years 2000-2002, and Fiscal Years 2003-2005)



Source: GAO analysis of LTC, OSCAR, and CMS regional office and state enforcement case files.

CMS Did Not Take Advantage of the Full Range of Sanctions for the Homes Reviewed

Among the homes we reviewed, CMS did not use the full range of its sanctions authority, generally imposing CMPs on the lower end of the allowable range.⁴⁵ In addition, CMS imposes DPNAs and involuntary terminations when they are mandatory, but generally not when they are discretionary. Homes subject to such mandatory sanctions have more opportunities to escape sanctions prior to implementation. The median per instance CMP implemented was \$2,000 in fiscal years 2000 through 2002 and \$1,750 in fiscal years 2003 through 2005, although the maximum per instance CMP can be as high as \$10,000. The median per day CMP

⁴⁵As previously described, the allowable range for a per day CMP is \$50 to \$10,000 for each day a home is noncompliant, and the allowable range for a per instance CMP is \$1,000 to \$10,000 for each episode of noncompliance.

implemented for nonimmediate jeopardy deficiencies was \$500 in fiscal years 2000 through 2002 and \$350 in fiscal years 2003 through 2005, significantly below the maximum of \$3,000 per day. In cases in which homes were cited for immediate jeopardy and the maximum potential per day CMP is \$10,000, the median per day CMP implemented was \$3,050 in fiscal years 2000 through 2002 and \$5,050 in fiscal years 2003 through 2005. According to one CMS official, the agency generally hesitates to impose CMPs that are higher than \$200 per day, in part because of concerns that higher per day CMPs could bankrupt some homes.⁴⁶ But the same official noted that the CMPs being imposed are not enough to “make nursing homes take notice” or to deter them from deficient practices. Another CMS official stated that some homes consider CMPs a part of the “cost of doing business” or as having no more effect than a “slap on the wrist.” Table 5 provides examples of homes we reviewed with implemented CMPs that were at the low end of the allowable CMP range.

Table 5: Examples of Homes with Low Implemented CMPs

Home's location	Surveyors' comments	Summary of deficiencies	CMP implemented	Allowable CMP range
Michigan	"A significant medication error occurred when resident #8 was administered [the wrong medication] over a three day period. The resident experienced hypoglycemia and required hospitalization. Upon return from the hospital there was evidence of actual harm: a decline in ability to perform activities of daily living."	1 G	\$1,500 per instance	\$1,000 - \$10,000 per instance of noncompliance
Texas	"Facility nurse aides failed to promptly report an allegation of possible sexual abuse. Resident reported the incident to two nurse aides, however, it was not reported. Also, reference checks were not documented for 4 employees and 4 employees had not attended an inservice [training session] on abuse."	3 F, 1 E	\$250 per day for 150 days	\$50 - \$3,000 per day for noncompliance other than immediate jeopardy

⁴⁶An official in one state told us that a home's financial status should not be considered when assessing CMPs because it could result in inconsistent CMPs for similar quality problems.

Home's location	Surveyors' comments	Summary of deficiencies	CMP implemented	Allowable CMP range
Texas	"There was an [immediate jeopardy deficiency for staff mistreatment of residents]. There was a failure to monitor residents in distress."	1 L (immediate jeopardy), 9 G	<p>Immediate jeopardy: \$3,050 per day for 14 days</p> <p>After immediate jeopardy removed: \$400 per day for 86 days; \$300 per day for 46 days; \$50 per day for 6 days</p>	<p>\$3,050 - \$10,000 per day for immediate jeopardy</p> <p>\$50 - \$3,000 per day for nonimmediate jeopardy</p>

Source: GAO analysis of CMS regional office and state case files and LTC.

Note: In addition to CMPs, CMS also imposed DPNAs and terminations—either mandatory or discretionary. All of the DPNAs but none of the terminations were implemented.

CMS is likely to impose DPNAs and terminations only when required to do so. However, CMS also has broad authority to impose DPNAs and terminations at its discretion, which can facilitate quicker implementation. Discretionary DPNAs and terminations can be implemented any time after a survey if the sanction is appropriate for the cited deficiencies and the required notice period is met. In contrast, the soonest that mandatory DPNAs and terminations for nonimmediate jeopardy can be implemented is 3 and 6 months, respectively, after the survey on which the deficiencies were cited.⁴⁷ Despite the greater expediency of discretionary DPNAs, 64 percent of the DPNAs CMS imposed were mandatory for fiscal years 2000 through 2005 for the homes we reviewed. For example, CMS imposed a total of six DPNAs during fiscal years 2000 through 2003 on a Pennsylvania home with demonstrated compliance problems. Of those six DPNAs, the first five were mandatory DPNAs. Only the last DPNA—imposed after multiple years of repeated noncompliance at the G-level or higher—was a discretionary DPNA.

Moreover, CMS imposed significantly more mandatory terminations than discretionary terminations; in fiscal years 2000 through 2005, 118 mandatory and 5 discretionary terminations were imposed on the homes we reviewed.⁴⁸ None of the mandatory terminations were implemented, but 2 discretionary terminations were implemented—one each in Michigan

⁴⁷By regulation, where no immediate jeopardy is found, CMS must provide homes with 15 days' notice before implementing any DPNA or termination. In cases of immediate jeopardy, however, the notice period is 2 days.

⁴⁸This analysis excludes Texas nursing homes because the data did not always allow us to distinguish between mandatory and discretionary terminations in Texas.

and Texas.⁴⁹ An official from the Texas state survey agency said that the CMS regional office in Dallas prefers to impose mandatory terminations, unless there is cause to believe there will be no improvements in the care provided by the nursing home. Mandatory terminations give homes 6 months to correct deficiencies before being implemented, as opposed to discretionary terminations, which can be implemented more quickly.

Even when CMS imposes terminations, their deterrent effect is weakened because the agency sometimes extends the termination dates. For example, CMS extended the discretionary termination dates for up to 6 months for some of the Texas homes we reviewed if the nursing homes had lower-level deficiencies on subsequent surveys. The termination date imposed on one Texas nursing home we reviewed was extended three times in fiscal year 2001 from the original date of April 18 to June 26, then to July 26, and finally to September 26. The first extension occurred because the home corrected the deficiencies that caused immediate jeopardy cited during the first survey. Therefore, despite the fact that this home continued to be found out of compliance for deficiencies such as mistreatment or neglect of residents during subsequent surveys, CMS extended the termination date twice to give the home an additional opportunity to correct those deficiencies and achieve substantial compliance. The termination ultimately was rescinded because the home corrected the deficiencies, but the home was subsequently cited for eight G-level deficiencies such as inadequate treatment or prevention of pressure sores, employing convicted abusers, and poor accident supervision or prevention. In 2004, the home closed voluntarily.

Despite Changes in Federal Enforcement Policy, Many Homes Continued to Cycle In and Out of Compliance

Despite changes in federal enforcement policy, almost half of the homes we reviewed—homes with prior serious quality problems—continued to cycle in and out of compliance, continuing to harm residents. These homes corrected deficiencies only temporarily and, despite having sanctions implemented, were again found to be out of compliance during subsequent surveys. Our analysis also showed that in some cases the double Gs did not result in immediate sanctions as required, even though about 40 percent of the homes were cited for double Gs during fiscal years 2000 through 2005. In addition, the term “immediate sanctions policy” is misleading because the policy requires only that sanctions be imposed, that is, that homes be notified immediately of CMS’s intent to implement

⁴⁹Our case file review found that one discretionary termination was implemented in Texas.

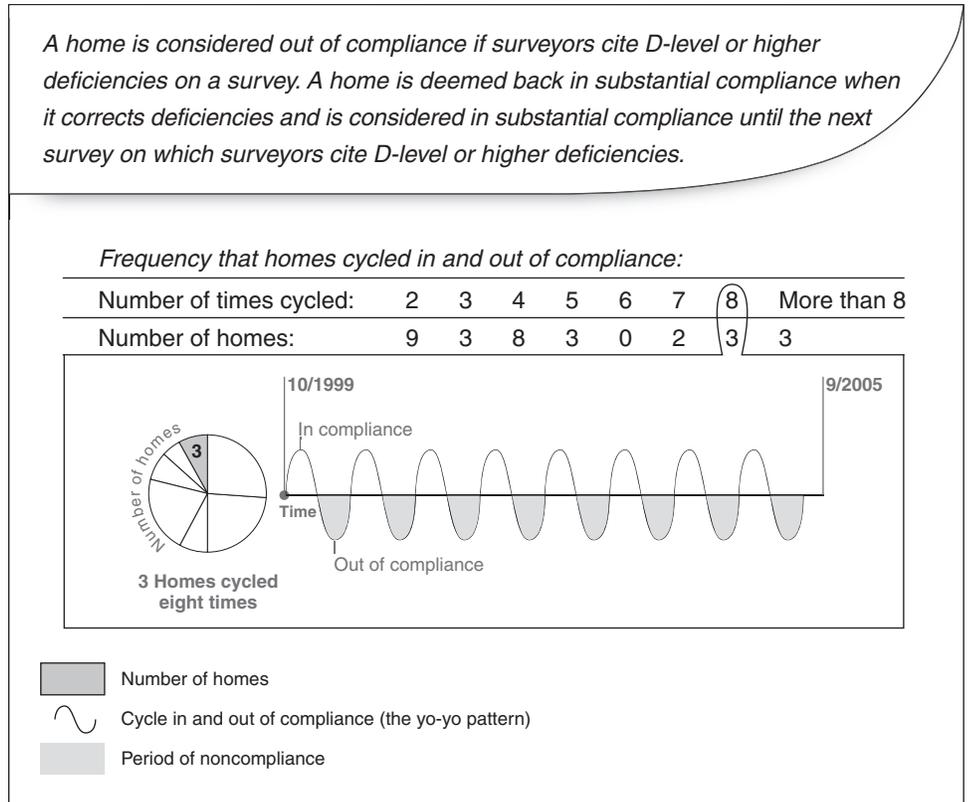
sanctions, not that sanctions must be implemented immediately. Furthermore, when a sanction is implemented for a double G citation, there is a lag time between when the double G occurs and the sanction's effective date. CMS cited double Gs multiple times at several of the homes we reviewed, suggesting that immediate sanctions did not deter future noncompliance as intended. Terminations of homes is infrequent, in part because of concerns such as local access to other nursing facilities and the effect on residents if they are moved, and in part because CMS allows some problem homes to continue operating until the homes eventually close voluntarily.

Many Homes Cycled In and Out of Compliance, Continuing to Harm Residents

Consistent with our earlier work, our current analysis showed that sanctions appear to have induced homes to correct deficiencies only temporarily because surveyors found that many of the homes we reviewed with implemented sanctions were again out of compliance on subsequent surveys.⁵⁰ Commenting on this phenomenon, state survey agency officials said that improvements resulting from sanctions might last about 6 months. From fiscal years 2000 through 2005, 31 of the 63 homes we reviewed (about 49 percent) cycled in and out of compliance more than once, harming residents, even after sanctions had been implemented, including 8 homes that did so seven times or more (see fig. 3).

⁵⁰ [GAO/HEHS-99-46](#).

Figure 3: Frequency that Reviewed Homes Cycled In and Out of Compliance, Fiscal Years 2000-2005



Source: GAO analysis of LTC, OSCAR, and CMS regional office and state enforcement case files.

Note: This figure illustrates the concept of a yo-yo pattern of compliance. While the time periods that a home is in or out of compliance appear to be of uniform duration, the duration can vary.

Each of the 31 homes that cycled in and out of compliance more than once during the period we reviewed had at least one G-level or higher deficiency in at least one period of noncompliance; 19 had at least one G-level or higher deficiency in every noncompliance period. Table 6 shows the number and length of noncompliance periods for a Michigan home we reviewed that cycled in and out of compliance nine times from fiscal years 2000 through 2005; the home remained open as of November 2006. Appendix IV provides similar examples for homes in California, Pennsylvania, and Texas. Homes' correction of deficiencies often was temporary, despite receiving sanctions. Thus, once the homes we reviewed corrected deficiencies, they maintained compliance for a median of 133 days and then cycled out of compliance again. Some homes cycled out

of compliance more quickly—homes were again out of compliance in 30 days or less about 8 percent of the time and within 60 days about 28 percent of the time.

Table 6: Example of a Michigan Nursing Home That Frequently Cycled In and Out of Compliance and Was Still Open as of November 2006

Noncompliance period in fiscal years 2000-2005 (no. of days)	Examples of the nature of deficiencies ^a	Summary of G-level or higher deficiencies	Enforcement action implemented ^b
1 st (41 days)	<ul style="list-style-type: none"> Inadequate treatment or prevention of pressure sores Poor quality of care 	1 G	<ul style="list-style-type: none"> Per instance CMP (\$1,000)
2 nd (185 days)	<ul style="list-style-type: none"> Poor nutrition Poor quality of care 	1 G	<ul style="list-style-type: none"> 1st per day CMP (\$10,000/day) 2nd per day CMP (\$100/day) Per instance CMP (\$1,500) Mandatory DPNA (109 days)
3 rd (176 days)	<ul style="list-style-type: none"> Inadequate treatment or prevention of pressure sores Poor accident supervision or prevention 	5 G	<ul style="list-style-type: none"> Per instance CMP (\$10,000) Mandatory DPNA (85 days)
4 th (158 days)	<ul style="list-style-type: none"> Resident abuse Employing convicted abusers 	1 J (immediate jeopardy), 3 G	<ul style="list-style-type: none"> 1st per day CMP (\$850/day) 2nd per day CMP (\$3,500/day) 3rd per day CMP (\$1,000/day) Discretionary DPNA (127 days)
5 th (107 days)	<ul style="list-style-type: none"> Resident abuse Failure to provide necessary services for daily living 	3 H, 3 G	<ul style="list-style-type: none"> Per day CMP (\$200/day) Discretionary DPNA (74 days)
6 th (94 days)	<ul style="list-style-type: none"> Poor accident supervision or prevention 	1 G	<ul style="list-style-type: none"> Per day CMP (\$350/day) Discretionary DPNA (62 days)
7 th (127 days)	<ul style="list-style-type: none"> Failure to provide necessary services for daily living Poor accident supervision or prevention 	1 J (immediate jeopardy), 1 G	<ul style="list-style-type: none"> 1st per day CMP (\$3,550/day) 2nd per day CMP (\$450/day) Mandatory DPNA (35 days)
8 th (89 days)	<ul style="list-style-type: none"> Inadequate treatment or prevention of pressure sores Employing convicted abusers Medication errors 	2 G	<ul style="list-style-type: none"> Per day CMP (\$500/day) Discretionary DPNA (59 days)
9 th (83 days)	<ul style="list-style-type: none"> Inadequate treatment or prevention of pressure sores Medication errors 	1 H	<ul style="list-style-type: none"> Per day CMP (\$750/day) Discretionary DPNA (51 days)

Source: GAO analysis of OSCAR, ETS, and AEM data.

Note: The table only includes federal sanctions imposed and implemented; sanctions imposed but not implemented and state sanctions are not included.

^aExamples of the nature of deficiencies include D-level or higher deficiencies.

⁴In a number of cases, more than one per day CMP is listed because CMS can raise or lower per day CMP amounts based on changes in deficiencies.

Relatively Few Homes Reviewed Were Cited for Double Gs

Despite the large number of G-level or higher deficiencies cited for the homes we reviewed, relatively few of these homes were cited for double Gs, and some double G citations did not result in sanctions. Over the 6-year period, 27 of the homes we reviewed had 69 double Gs. However, 47 of the homes had 444 G-level or higher deficiencies. We found no record that CMS imposed a sanction for 15 of the 69 double Gs, but the data did show that CMS implemented sanctions for the remaining double G cases.⁵¹

Across the four states we reviewed, there was variation in the citation of G-level or higher deficiencies and the implementation of immediate sanctions. For example, from fiscal years 2000 through 2005, 35 percent of G-level or higher deficiencies and 52 percent of double Gs among the homes we reviewed were cited in Michigan, while 9 percent of the G-level or higher deficiencies and 4 percent of the double Gs were cited in homes in California. In California, complaints typically are investigated under state licensure authority and the findings generally are not recorded in the same manner as deficiencies cited under the federal process,⁵² which may contribute to lower double G citation rates in the state.⁵³ Thus, California homes are not cited for a double G when the subsequent deficiency equivalent to a G-level or higher deficiency was found during a complaint

⁵¹In July 2003, we reported that from January 2000 through March 2002, states did not refer a substantial number of nursing homes with a pattern of harming residents to CMS for immediate sanctions. See [GAO-03-561](#). Eight of the 15 cases occurred after March 2002. From fiscal years 2000 through 2005, 40 CMPs and 25 DPNAs were implemented during periods of noncompliance in which there was a double G.

⁵²California records findings from complaints investigated under state licensure in a separate and dedicated state-licensure component of the federal system for tracking complaints. The state complaints are recorded using the state system for classifying violations. According to the state, complaints investigated under state licensure are recorded separately because state law prohibits the issuance of both a state citation, which carries with it a mandatory state civil monetary penalty, and the recommendation that a federal CMP be imposed.

⁵³If, during a complaint investigation, state surveyors identify deficiencies that would be equivalent to immediate jeopardy or substandard quality of care, the surveyors automatically complete the investigation under the federal enforcement process.

investigation.⁵⁴ Complaint surveys with G-level or higher deficiencies often lead to double Gs. One CMS official stated that if complaints against California nursing homes were investigated under the federal complaint investigation procedure, more double Gs would be cited in California.⁵⁵ The California Department of Health Services conducted a pilot to test the use of the federal complaint procedure in select district offices, in part because of the low double G citation rate. As of November 2006, the department decided not to expand or complete a formal evaluation of the pilot; instead, the department is focusing on eliminating its backlog of complaints and initiating complaint investigations within required time frames.⁵⁶

Immediate Sanctions Often Not Immediate and Do Not Appear to Deter Noncompliance

Although referred to as the “immediate sanctions” policy, the term is misleading because (1) there is a lag between when the double G is cited and when the sanction is implemented, negating the sanction’s immediacy; (2) the policy only requires that sanctions be imposed immediately, which does not guarantee that the sanction will be implemented; and (3) homes may not actually pay a CMP, the most frequently implemented sanction, until years after citation of the double G because payment is suspended until after appeals have been adjudicated. Delays in implementing DPNAs and in collecting CMPs—which diminish their immediacy—coupled with their nominal amounts may undermine their deterrent effect.

⁵⁴The violations and resulting sanctions are categorized according to the state’s classification framework. For example, a class AA violation is one that, among other things, is a “direct proximate cause of death of a patient or resident,” and the resulting sanction is a fine from \$25,000 to \$100,000. The state system for classifying violations and sanctions does not directly correlate to the federal scope and severity grid, and there is no direct equivalent to a G-level deficiency. According to a California state survey agency official, a class A violation is approximately equivalent to a G-level deficiency, but there may be instances in which other classes of violations are also equivalent to a G-level deficiency.

⁵⁵Although California homes with histories of harming residents may not be cited for double Gs and thus referred for immediate sanctions under federal requirements, the state has its own policy for encouraging such homes to improve quality of care—the state can triple CMPs for violations that are repeated in a 12-month period. An assessment of the effectiveness of California’s approach under state licensure for sanctioning homes with repeat violations was beyond the scope of this report.

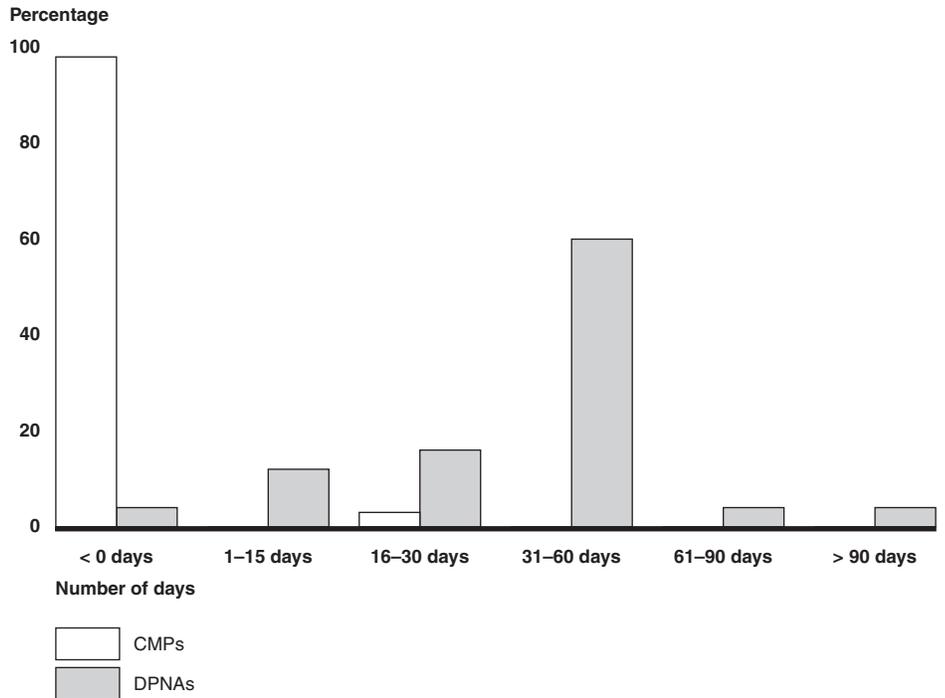
⁵⁶The select district offices that participated in the pilot will continue to cite federal deficiencies and impose federal sanctions; in the uncommon situation where there is a violation of a state regulation but not a federal regulation, the offices will use a state sanction. According to comments from California, if complaint investigations find harm to residents, all district offices are directed to complete the investigations under state licensure authority or the federal complaint procedure, depending on multiple variables.

Immediate sanctions often are not immediate because there is a lag time between the identification of deficiencies during the survey and when a sanction (i.e., a CMP or DPNA) is actually implemented.⁵⁷ CMS implemented about 68 percent of the DPNAs for double Gs among the homes we reviewed during fiscal years 2000 through 2005 more than 30 days after the survey (see app. V). In contrast, CMPs can go into effect as early as the first day the home was out of compliance, even if that date is prior to the survey date, because, unlike DPNAs, CMPs do not require a notice period.⁵⁸ About 98 percent of CMPs imposed for double Gs took effect on or before the survey date. Figure 4 illustrates the lag time that can occur between the survey date and the implementation date of the sanction, especially with regard to DPNAs. For example, in fiscal years 2000 through 2005, 60 percent of the DPNAs in the homes we reviewed were implemented 31 to 60 days from the date of the survey citing deficiencies. In contrast, nearly all CMPs were implemented on or before the survey date.

⁵⁷We excluded terminations from this analysis because terminations rarely are implemented.

⁵⁸When the CMP goes into effect, the fine starts accruing as of that date.

Figure 4: Number of Days between Survey and Implementation of CMPs and DPNAs among Homes Reviewed, Fiscal Years 2000-2005



Source: GAO analysis of LTC, OSCAR, and CMS regional office and state enforcement case files.

Note: CMPs can take effect prior to the date of the survey, if the date of noncompliance can be established. In cases where an appeal has changed the determination of the date of noncompliance, the implementation date of CMPs would be modified accordingly. Some CMPs and DPNAs were not included in this analysis because implementation dates were not available.

While the immediate sanctions policy requires that sanctions be imposed immediately, it is silent on how quickly sanctions should be implemented. A sanction is considered imposed when a home is notified of CMS’s intent to implement a sanction—15 days from the date of the notice. If during the 15-day notice period the nursing home corrects the deficiencies, no sanction is implemented. Thus, even under the immediate sanctions policy, which is intended to eliminate grace periods for nursing homes repeatedly cited for deficiencies at the actual harm level or higher, nursing homes have a de facto grace period.

While CMPs can be implemented closer to the date of survey than DPNAs, the immediacy and the effect of CMPs may be diminished by (1) the significant time that can pass between the citation of deficiencies on a survey and the home’s payment of the CMP and (2) the low amounts

imposed, as described earlier in this report.⁵⁹ By statute, payment of CMPs is delayed until appeals are exhausted.⁶⁰ For example, a Michigan home did not pay its CMP of \$21,600 until more than 2 years after a February 2003 survey had cited a G-level deficiency.⁶¹ (See fig. 5.) The February G-level citation was a repeat deficiency: less than a month earlier, the home had received another G-level deficiency in the same quality of care area. The delay in collecting the fine in this case is consistent with a 2005 report from the Office of Inspector General of the Department of Health and Human Services that found that the collection of CMPs in appealed cases takes an average of 420 days—a 110 percent increase in time over nonappealed cases—and “consequently, nursing homes are insulated from the repercussions of enforcement by well over a year.”⁶²

Unlike the Social Security Act, the federal Surface Mining Control and Reclamation Act of 1977 provides for the collection of CMPs prior to exhaustion of administrative appeals.⁶³ Under this statute, mining operators charged with civil money penalties have 30 days to either pay the penalty in full or forward the proposed amount for placement in an escrow account pending resolution of appeals. This provision, requiring escrow deposit of a proposed penalty assessment, has been upheld by three federal circuit courts of appeal, all citing the various procedural safeguards as helping to ensure sufficient due process to affected operators.⁶⁴ For example, these courts cited the availability of an informal conference at which mining operators may present information relevant to an assessment of a penalty. It is unclear whether the informal dispute resolution process available to nursing homes would provide due process similar to that provided under the Federal Mining statute. Nonetheless, the

⁵⁹As noted, unlike CMPs, payment denial for DPNAs is required upon implementation, not after appeal.

⁶⁰See 42 U.S.C. §§ 1395i-3(h)(2)(B)(ii), 1396r(h)(3)(C)(ii), and 1320a-7a.

⁶¹In contrast, Pennsylvania nursing homes pay state CMPs upon implementation, even if an appeal is pending. However, the state agency may grant exceptions to this requirement for good cause.

⁶²See Department of Health and Human Services, Office of Inspector General, *Nursing Home Enforcement: The Use of Civil Money Penalties*, OEI-06-02-00720 (April 2005).

⁶³See the federal Surface Mining Control and Reclamation Act of 1977, Pub. L. No. 95-87, § 518, 91 Stat. 499 (1977) (classified to 30 U.S.C. § 1268, as amended).

⁶⁴*B & M Coal v. Office of Surface Min. Reclamation*, 699 F. 2d 381 (7th Cir. 1983); *Graham v. Office of Surface Min. Reclamation*, 722 F. 2d 1106 (3rd Cir. 1983); *Blackhawk Mining Co., Inc. v. Andrus*, 756 F. 2d. 755 (6th Cir. 1983).

Social Security Act would preclude a more expeditious collection of nursing home CMPs.

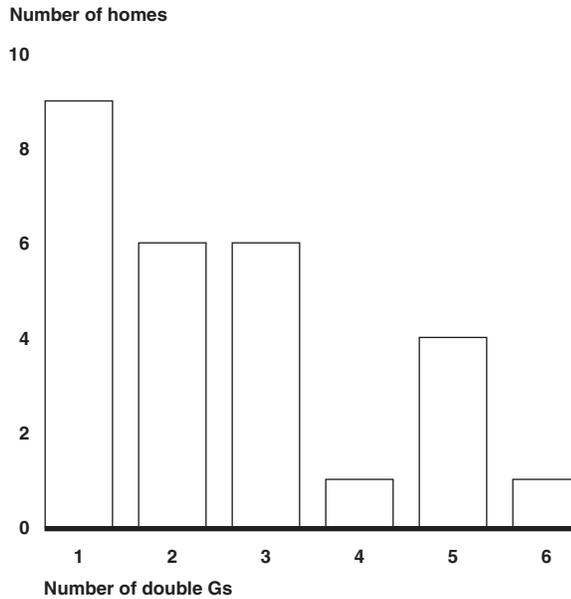
Figure 5: Lag Time between Survey and CMP Payment for a Michigan Nursing Home



Source: GAO analysis of LTC, CMPTS, and CMS regional office and state enforcement case files.

Despite the potentially negative consequences, CMS's implementation of the immediate sanctions policy does not appear to deter homes from harming residents in the future. Two-thirds (18) of the 27 nursing homes cited for double Gs that subsequently had sanctions implemented went on to be cited again for one or more additional double Gs. (See fig. 6.)

Figure 6: Number of Homes with One or More Double Gs, Fiscal Years 2000-2005



Source: GAO analysis of CMS PDQ.

Termination Used Infrequently

Nursing homes, even those that repeatedly harm residents, are infrequently terminated because of CMS’s concerns about access to other sources of nursing care and the impact of moving residents. Of the homes we reviewed, two were terminated involuntarily for cause. Another nine homes closed voluntarily,⁶⁵ which is not a sanction because the homes chose to close. However, the actual reason for closure is not always clear; a home may close to avoid involuntary termination because of quality problems cited by state surveyors.⁶⁶ Allowing a problem home to close voluntarily rather than terminating it may result in continuing harm to residents until the home decides to close. For example, two homes we

⁶⁵CMS classifies the reasons for voluntary closure as “merger/closure;” “dissatisfaction with reimbursement;” “risk of involuntary termination;” and “other reasons for withdrawal.”

⁶⁶In commenting on a draft of this report, CMS noted that some of the homes classified as voluntary terminations closed as a result of coordinated CMS and state actions. In its comments, Michigan stated that some voluntary terminations were the result of business decisions after the homes received survey results that warranted serious sanctions.

reviewed in Pennsylvania and Texas closed voluntarily, but the histories of both homes show that they were repeatedly cited for harming residents from fiscal year 2000 through the time of their closures, over 4 years later in January 2004. The Pennsylvania home cycled in and out of compliance 4 times during the period we reviewed and had noncompliance periods lasting an average of 170 days. The Texas home cycled in and out of compliance 10 times during the period reviewed and had average noncompliance periods of 46 days. On average, both homes had about 6 G-level or higher deficiencies per year in areas such as inadequate treatment or prevention of pressure sores and resident abuse.⁶⁷ The home in Pennsylvania had an average of 31 other deficiencies per year and the Texas home had an average of 27.⁶⁸

Four homes we reviewed had similar deficiency histories. Two closed voluntarily and two remained open as of November 2006 (see table 7). Although the homes that remained open met the deadline to correct deficiencies before the termination would have been implemented, a home's ability to correct deficiencies in a specified period of time may not be the strongest criteria upon which to determine whether a home should remain open, because correcting deficiencies does not ensure that the home will improve residents' quality of care and does not prevent the home from again falling out of compliance. For example, the California and Michigan homes in table 7 were still operating as of November 2006 but cycled in and out of compliance four and seven times, respectively.

⁶⁷Nationwide, the average number of serious deficiencies per home from fiscal years 2000 through 2005 was less than one.

⁶⁸This analysis includes cited deficiencies at the D, E, or F levels of scope and severity. We include these deficiencies because, as we previously reported, understatement by state surveyors of serious deficiencies that cause actual harm or immediate jeopardy to residents remains a concern. See [GAO-06-117](#).

Table 7: Examples of Homes' Deficiency Histories and Termination Actions, Fiscal Years 2000-2005

Examples of deficiencies causing harm to residents ^a	Deficiency history	Enforcement history ^b	Current status
California home^c			
<ul style="list-style-type: none"> A resident choked to death when the suction machines that should have been maintained in working order did not have the requisite parts. Indeed, during an unannounced inspection 2 days following the death of this resident, it was noted that there were no functional suction machines in the facility. 	<ul style="list-style-type: none"> 173 D-level or higher deficiencies Cycled in and out of compliance 4 times 	<ul style="list-style-type: none"> DPNA (142 days) CMP (\$193,780) Mandatory termination imposed (4 times) Discretionary termination imposed (0 times) 	In operation as of November 2006.
Michigan home			
<ul style="list-style-type: none"> The facility failed to provide proper respiratory treatment and care for a resident, resulting in the resident's hospitalization for acute respiratory failure. During an inspection, several residents' pressure sores were observed to be untreated. For example, one resident had two areas of dead tissue on his feet. The facility acknowledged that the resident should have been wearing protective heel pads when in bed, and yet his bare feet were uncovered, both heels rested directly on the mattress, and he was not wearing heel protectors, which were lying nearby. 	<ul style="list-style-type: none"> 95 D-level or higher deficiencies Cycled in and out of compliance 7 times 	<ul style="list-style-type: none"> DPNA (58 days) CMP (\$40,970) Mandatory termination imposed (7 times) Discretionary termination imposed (0 times) 	In operation as of November 2006.
Pennsylvania home			
<ul style="list-style-type: none"> "Resident eloped and was found on the courtyard froze (sic) to death." "A resident was found to have bruises on the inner thighs and arms and appeared to be a victim of abuse. The staff did not report this to the local police and bathed resident prior to assessment for sexual abuse." 	<ul style="list-style-type: none"> 159 D-level or higher deficiencies, fiscal years 2000-2004 Cycled in and out of compliance 4 times 	<ul style="list-style-type: none"> DPNA (229 days) CMPs (\$47,700) Mandatory termination imposed (6 times) Discretionary termination imposed (0 times) 	Closed January 2004. Reason for closure: voluntary-merger/closure.

Examples of deficiencies causing harm to residents ^a	Deficiency history	Enforcement history ^b	Current status
Texas home			
<ul style="list-style-type: none"> “Conditions remain poor, residents are not clean or groomed, drug errors continue, restorative care is poor. Will give facility the full 6 months to try to come into compliance, continue all remedies.” 	<ul style="list-style-type: none"> 141 D-level or higher deficiencies, fiscal years 2000-2004 Cycled in and out of compliance 10 times 	<ul style="list-style-type: none"> DPNA (228 days) CMPs (\$146,244) Mandatory or discretionary termination imposed (10 times)^d 	<p>Closed January 2004. Reason for closure: voluntary-merger/closure.</p>

Source: GAO analysis of LTC, OSCAR, CMPTS, and CMS regional office and state enforcement files.

^aStatements are from surveyors’ notes and are either paraphrased or direct quotes.

^bThe CMP amount reflects the amount payable by the home, but is not necessarily the amount the home actually paid.

^cThese data likely understate the quality problems at this home because California primarily conducts complaint investigations under its state licensure authority and did not record serious deficiencies identified during such investigations in OSCAR. In commenting on a draft of this report, California noted that this home did receive the highest state deficiency citation and was assessed a state CMP of \$60,000.

^dBecause the Texas data did not always allow us to distinguish between mandatory and discretionary terminations, we report the total number of imposed terminations.

According to CMS and state officials, factors that may prevent or delay termination of problem nursing homes include (1) concerns regarding lack of access to alternate local nursing facilities, (2) the potential for resident trauma as a result of transfer to another home, (3) the preference of residents’ families for homes located close by, and (4) pressure to keep homes open from families and other stakeholders.⁶⁹ Our analysis of alternatives to the 4 poorly performing homes in table 7—those that closed voluntarily or are still open—showed that there were from 2 to 37 homes within 10 miles of these homes, and from 5 to 120 homes within 25 miles.⁷⁰

⁶⁹In commenting on a draft of this report, Michigan noted that relocation is especially challenging in rural areas or for residents with special care needs.

⁷⁰For this analysis we used CMS’s Nursing Home Compare Web site (www.medicare.gov/NHCompare), which permits users to search for nursing homes by proximity to specific zip codes. We did not analyze the number or availability of beds in the homes. There may have been some changes in the number of nursing homes near the two homes that closed voluntarily in January 2004 because of the time difference between when these homes closed and the date we conducted our analysis (June 2006).

Complex Immediate Sanctions Policy and Data Limitations Hamper CMS Management of Enforcement

While the goal of enforcement is to help ensure nursing home compliance with federal quality requirements, CMS management of the process is hampered by the complexity of its immediate sanctions policy and by its fragmented and incomplete data systems. The agency's immediate sanctions policy, intended to deter repeat noncompliance, fails to hold some homes accountable for repeatedly harming residents. In addition, although CMS has developed a new data system, the system's components are not integrated and the national reporting capabilities are not complete, hampering the agency's ability to track and monitor enforcement. Finally, CMS has taken some steps intended to improve enforcement of nursing home quality requirements, such as developing guidance to help ensure greater consistency across states in CMP amounts, revising its Special Focus Facility program, and commissioning two studies to examine the effectiveness of nursing home enforcement. It is not clear, however, the extent to which—or when—these initiatives will address the enforcement weaknesses we found.

Immediate Sanctions Policy Is Complex and Fails to Hold Some Homes Accountable

The double G immediate sanctions policy is complex and fails to hold some homes accountable. In 2003, we reported that the early implementation of the policy was flawed.⁷¹ We found that between January 2000 and March 2002 over 700 cases that should have been referred for immediate sanctions were not because (1) the policy was misunderstood by some states and regional offices, (2) states lacked adequate systems for identifying deficiencies that triggered an immediate sanction, and (3) actions of two of the four states were at variance with CMS policy. CMS developed an on-line reporting tool for use by survey agency and regional office staff to automate the identification of double Gs.⁷² CMS also offered training sessions and issued additional guidance to state survey agencies and regional offices. While the on-line reporting tool and training were useful, they did not address the underlying complexity of the policy. For example, CMS staff told us that in developing the tool they had initially misinterpreted the double G immediate sanctions policy. As a result, the tool produced many false positives: that is, it identified deficiencies as triggering an immediate sanction that in fact did not occur. Moreover, a December 2005 report by the Office of the Inspector General of the Department of Health and Human Services also reported that state

⁷¹GAO-03-561.

⁷²The on-line reporting tool known as Providing Data Quickly (PDQ) is available through a Web site for use only by CMS and state survey agency employees.

survey agency staff continued to have difficulty identifying double G cases.⁷³

Furthermore, our analysis of CMS's application of the policy to the homes we reviewed demonstrated that the policy's complex rules allowed homes to escape immediate sanctions even if they repeatedly harmed residents; these rules include (1) the requirement for an intervening period of compliance, (2) the clearing effect of standard surveys, and (3) the lack of differentiation between single and multiple instances of harm. Such rules may in part explain why the homes we reviewed only had 69 instances of immediate sanctions over a 6-year period, despite being cited 444 times for deficiencies that harmed residents.

Intervening period of compliance. G-level or higher deficiencies only count toward a double G immediate sanction if the home has an intervening period of compliance between the two G-level or higher deficiencies. In order to receive an immediate sanction, a home has to achieve substantial compliance between the pair of surveys on which the G-level or higher deficiencies are cited. As a result of this rule, homes that do not correct deficiencies do not receive immediate sanctions, while homes that do correct deficiencies do receive immediate sanctions. CMS officials stated that the intent of the policy as written was to give nursing homes a chance to correct deficiencies and achieve a period of compliance. Without this provision, CMS officials believe that homes could get caught in endless double G cycles.

The following example illustrates how the policy allows nursing homes to escape immediate sanctions if they do not correct deficiencies and have ongoing noncompliance periods.⁷⁴

- In a 9-month time period, a Pennsylvania home had seven surveys, each with at least one G-level deficiency (a total of 19 G-level deficiencies).⁷⁵ However, double G immediate sanctions were triggered by only two pairs

⁷³Department of Health and Human Services, Office of Inspector General, *State Referral of Nursing Home Enforcement Cases*, OEI-06-03-00400 (December 2005).

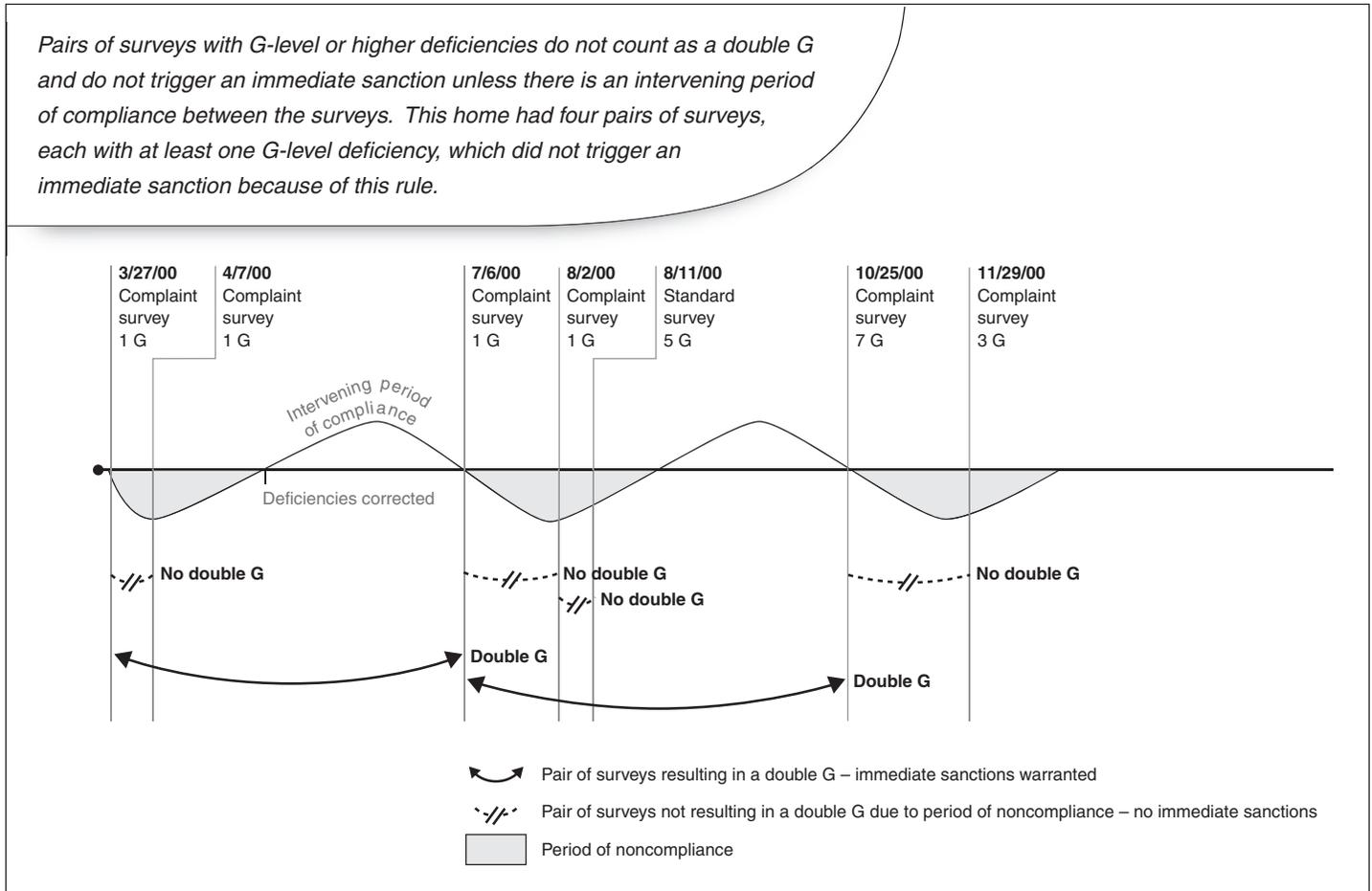
⁷⁴This example only includes a limited portion of the home's compliance history from fiscal years 2000 through 2005.

⁷⁵Three additional surveys conducted from March 27, 2000, through November 29, 2000, were not included in this analysis because none of the surveys had deficiencies at the G level or higher.

of surveys because the home had failed to correct some deficiencies before the next survey that again found actual harm.⁷⁶ Figure 7 illustrates how some pairs of surveys with G-level deficiencies do not count as a double G because of the intervening period of compliance rule. For example, both the March and April surveys cited G-level deficiencies. However, the pair of surveys did not result in a double G, which would have triggered immediate sanctions because the home did not correct the G-level deficiency cited on the March survey before the next G-level deficiency was cited in April. Following the April survey, the home corrected the deficiencies, resulting in a period of compliance. In July, another survey found a new G-level deficiency. Because of the intervening period of compliance, the March and July surveys resulted in a double G, for which immediate sanctions would have been warranted.

⁷⁶While immediate sanctions were not imposed, CMS may have continued an existing sanction or imposed a new sanction, which was rescinded because the home corrected the deficiency.

Figure 7: Impact of Intervening Periods of Compliance Rule on Immediate Sanctions for One Pennsylvania Nursing Home, 2000



Source: GAO analysis of OSCAR and PDQ.

Clearing effect of standard surveys. Under the double G immediate sanctions policy, a standard survey without a G-level or higher deficiency “clears the home’s record” for the purposes of determining whether a double G occurred.⁷⁷ As a result of this rule, surveys with G-level or higher deficiencies that occurred before the standard survey without a G-level or

⁷⁷This aspect of the immediate sanctions policy does not affect the retention of data on prior G-level or higher deficiencies in CMS’s OSCAR database.

higher deficiency are not considered in determining whether a double G should be cited and an immediate sanction should be imposed. CMS officials believe that it is appropriate for standard surveys without G-level or higher deficiencies to clear the home's record for double G purposes because standard surveys are comprehensive and occur regularly. Yet, we have previously reported that weaknesses in the survey process result in surveyors' missing serious deficiencies on standard surveys.⁷⁸ Moreover, variability among states in the citation of serious deficiencies suggests that some states may not be citing deficiencies at the appropriate scope and severity (see app. II). For example, according to California officials, the guidance the state received from the CMS regional office created confusion as to what constituted actual harm, and this confusion contributed to the decline in citations of serious deficiencies in California. The regional office clarified its guidance in late 2004.

The following example illustrates how a standard survey without G-level or higher deficiencies affects double G determinations and how having uncorrected deficiencies can prevent a home from receiving an immediate sanction.⁷⁹

- In approximately a 12-month period, a Michigan home had five surveys, four of which had one G-level deficiency. However, the G-level deficiencies triggered double G immediate sanctions only once instead of three times because in one instance a standard survey cited no G-level deficiencies and in the other there was no intervening period of compliance.⁸⁰ Figure 8 illustrates how some pairs of surveys with G-level deficiencies do not count as double Gs because of the clearing effect of standard surveys. For example, state surveyors found a G-level deficiency during a January 2000 complaint survey. However, on the home's standard survey a month later (February 2000), no G-level or higher deficiencies were found by surveyors. As a result, when surveyors found another G-level deficiency on a complaint survey several months later (November 2000), the G-level deficiency on the home's January survey was not considered, and no immediate sanctions were triggered. The pair of

⁷⁸See [GAO/HEHS-98-202](#), [GAO-03-561](#), and [GAO-06-117](#).

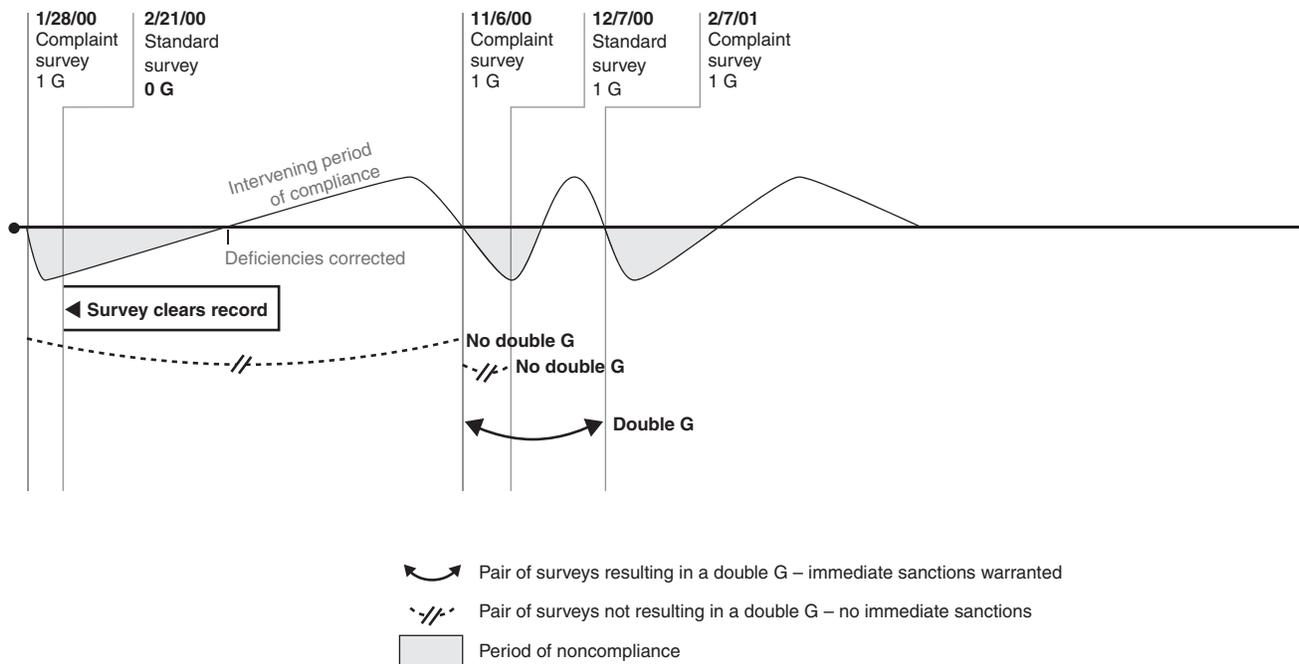
⁷⁹This example only includes a limited portion of the home's compliance history from fiscal years 2000 through 2005.

⁸⁰While immediate sanctions were not imposed, CMS may have continued an existing sanction or imposed a new sanction, which was rescinded because the home corrected the deficiency.

surveys in January 2000 and November 2000 did not trigger immediate sanctions because, in effect, the February 2000 standard survey cleared the home's record.

Figure 8: Impact of Clearing Effect Rule on Immediate Sanctions for One Michigan Nursing Home, 2000-2002

Pairs of surveys with G-level or higher deficiencies do not count as a double G and do not trigger an immediate sanction when there is a **standard** survey with **no** G-level or higher deficiencies between the pair. This home had one pair of surveys, each with one G-level deficiency, which did not trigger an immediate sanction because of the clearing effect rule. The pair of surveys (beginning on 11/6/00) also did not trigger an immediate sanction because of the intervening period of compliance rule.



Source: GAO analysis of OSCAR and PDQ.

Multiple instances of harm. Multiple G-level or higher deficiencies identified on a survey that results in an immediate sanction are sometimes treated the same, in terms of enforcement, as a single instance of harm or immediate jeopardy cited on a survey. We examined the sanctions imposed for a single versus multiple instances of harm and found that the sanctions can be quite similar, despite the significant differences in the

number of deficiencies.⁸¹ The following example involves two surveys of a Michigan home with a history of repeated noncompliance. On a survey with only 1 G-level deficiency, CMS implemented a \$350 per day CMP and a discretionary DPNA. On a different survey with 33 D-level or higher deficiencies and 6 G-level or higher deficiencies, CMS implemented a \$200 per day CMP and a discretionary DPNA. We found similar examples among other homes we reviewed.

We discussed our concerns with CMS about how the double G immediate sanctions policy allows some homes to avoid immediate sanctions. CMS officials stated that regardless of the policy, state and regional office officials retain the discretion to impose immediate sanctions even when not required by the policy. However, based on a discussion with CMS officials, we believe that, instead of imposing sanctions of appropriate severity, state and regional office officials may impose weaker sanctions for problem homes that have escaped immediate sanctions because of the complexities of the policy. CMS agreed that this could happen.

CMS Oversight Continues to Be Hampered by Data Limitations

Fragmented data systems and incomplete national reporting capabilities continue to hamper CMS's ability to track and monitor enforcement. In March 1999, we reported that CMS lacked a system for effectively integrating enforcement data nationwide and that the lack of such a system weakened oversight.⁸² Since 1999, CMS has made progress in developing an enforcement data collection system called the ASPEN Enforcement Manager (AEM). However, while AEM collects valuable data from the states and regions, it is not fully integrated with other CMS systems used to track nursing home survey and enforcement activities. For example, when regional and state survey officials want to evaluate complaint and enforcement data, they must access one system for complaint data and then access another system, AEM, for enforcement data. Because there is no direct interface between the two systems, CMS and states must rely on fragmented data systems for tracking and monitoring enforcement. Furthermore, CMS officials told us that the agency does not have a concrete plan to use the enforcement data to

⁸¹To gain a sense of how frequently multiple instances of harm are treated the same as single instances of harm, we examined the enforcement history of some of the homes cited with double Gs. Over half of the surveys examined with multiple G-level or higher deficiencies received sanctions similar to homes with a single G-level or higher deficiency.

⁸²[GAO/HEHS-99-46](#).

improve monitoring and oversight but that some national enforcement reports are under development.

From 2000 to 2004, CMS tracked sanctions with LTC, a data system developed in the Chicago region that became operational in all 10 CMS regions in 2000. LTC was a relatively simple system designed to collect sanctions data, automatically generate sanction imposition letters, and automatically calculate the 35 percent reduction in CMPs for homes that waive the right to appeal deficiencies. LTC was not always useful for enforcement oversight because it was sometimes incomplete. Data entry into the LTC system was optional, and many regional and state surveyors continued to rely on their own, state-specific tracking systems. Moreover, during the time LTC was in use, states and regions were expected to continue updating the enforcement component of OSCAR, which duplicated some of the information in LTC. This required separate manual data entry into both LTC and OSCAR. We were told by regional office officials that sometimes only one of the files would be updated. Furthermore, LTC had no internal quality control checks for ensuring all fields were completed or that the data were accurate; in its design of LTC, CMS chose flexibility in modifying the data to accommodate special circumstances over a more rigid field edits system that would have controlled the data more tightly.

Since October 1, 2004, CMS has used AEM to collect state and regional data on sanctions and improve communications between state survey agencies and CMS regional offices. Specifically, AEM was designed to provide real-time entry and tracking of sanctions, issue monitoring alerts, generate enforcement letters, and facilitate analysis of enforcement patterns. CMS expects that the data collected in AEM will enable states, CMS regional offices, and the CMS central office to more easily track and evaluate sanctions against nursing homes as well as respond to emerging issues. Developed by CMS's central office primarily for use by states and regions, AEM is one module of a broader data collection system called ASPEN. There are a number of other modules under the ASPEN umbrella, including the ASPEN Complaints/Incidents Tracking System (ACTS) module. The ASPEN modules—and other data systems related to enforcement such as the financial management system for tracking CMP collections—are fragmented and lack automated interfaces with each other. As a result, enforcement officials must pull discrete bits of data from the various systems and manually combine the data to develop a full enforcement picture. For example, if regional office officials want to review a home's complaint history, they must access ACTS to print a report on complaints, access AEM to print a report on corresponding

sanctions, manually compare the two reports, and then access the CMP tracking system to determine whether a corresponding CMP was paid. Each step adds to staff workload.

AEM collects potentially useful enforcement data from the states and regions, but, as described, CMS has not integrated AEM with the other data collection systems (e.g., ACTS); furthermore, the agency has not defined a plan for using the AEM data to inform the tracking and monitoring of enforcement through national enforcement reports. In a December 2004 CMS report, the agency stated that AEM “will permit meaningful comparisons of like measures and will serve as a primary tool on which to base policy decisions, new initiatives and strategies for improving care to our Nation’s nursing home population.”⁸³ While CMS is developing a few draft national enforcement reports, it has not developed a concrete plan and timeline for producing a full set of reports that use the AEM data to help in assessing the effectiveness of sanctions and its enforcement policies. In addition, while the full complement of enforcement data recorded by the states and regional offices in AEM is now being uploaded to CMS’s national system, CMS does not intend to upload any historical data. Efforts to track and monitor enforcement would be greatly enhanced by reports that contain the historical data; for example, with historical data the agency could generate reports that provide a longitudinal perspective of a home’s compliance history, compare trends across states and regions, and, overall, help evaluate the effectiveness of sanctions and policies. Finally, like LTC, AEM has quality control weaknesses. While AEM has some automatic quality control mechanisms to ensure that the data entered are complete and in a valid format, there are no systematic quality control mechanisms to ensure that the data entered are accurate. For example, while the system automatically requires the entry of valid survey dates, CMS does not conduct periodic data audits to check that the survey dates are correct.

CMS officials told us they will continue to develop and implement enhancements to AEM to expand its capabilities over the next several years. However, until CMS develops a plan for integrating the fragmented systems and for using AEM data—along with other data the agency collects—efficient and effective tracking and monitoring of enforcement

⁸³CMS’s December 2004 “Action Plan (For Further Improvement of) Nursing Home Quality.”

will continue to be hampered and, as a result, CMS will have difficulty assessing the effectiveness of sanctions and its enforcement policies.

Other CMS Initiatives to Improve Enforcement

In addition to its efforts to implement a new data system for managing enforcement, CMS has taken other steps to improve its enforcement of nursing home quality requirements. For example, the agency has developed guidance to help ensure greater consistency across states in CMP amounts imposed, revised its Special Focus Facility program, and commissioned two studies to examine the effectiveness of nursing home enforcement.⁸⁴

To ensure greater consistency in CMP amounts proposed by states and imposed by regions, CMS, in conjunction with state survey agencies, developed a grid that provides guidance for states and regions. The CMP grid lists ranges for minimum CMP amounts while allowing for flexibility to adjust the penalties on the basis of factors such as the deficiency's scope and severity, the care areas where the deficiency was cited, and a home's past history of noncompliance. In August 2006, CMS completed the regional office pilot of its CMP grid. The results of the pilot, which are currently being analyzed, will be used to determine how the grid should be used by states; its use would be optional to provide states flexibility to tailor sanctions to specific circumstances.

CMS revised its Special Focus Facility program, an initiative intended to increase the oversight of homes with a history of providing poor care. We had previously reported that the program was worthwhile but that its narrow scope excluded many homes that provide poor care.⁸⁵ Moreover, according to CMS, the goal of two surveys per home per year was never achieved because of the relatively low priority assigned to the program and the lack of state survey agency resources. In December 2004, CMS announced three changes in the operation of the program. First, CMS expanded the scope of the program from about 100 homes nationwide to about 135 homes by making the number of Special Focus Facilities in each state proportional to the number of nursing homes. Second, CMS revised the method for selecting nursing homes by reviewing 3 years' rather than

⁸⁴Additional CMS nursing home initiatives are described in CMS's 2007 "Action Plan for (Further Improvement of) Nursing Home Quality."

⁸⁵GAO, *Nursing Homes: Sustained Efforts Are Essential to Realize Potential of the Quality Initiatives*, GAO/HEHS-00-197 (Washington, D.C.: Sept. 28, 2000).

1 year's worth of deficiency data. This change was intended to ensure that the homes in the program had a history of noncompliance rather than a single episode of noncompliance. Third, CMS strengthened its enforcement for Special Focus Facilities by requiring immediate sanctions for homes that failed to significantly improve their performance from one survey to the next and by requiring termination for homes with no significant improvement after three surveys over an 18-month period.⁸⁶ Despite these changes, however, many homes that could benefit from enhanced oversight and enforcement are still excluded from the program. As noted earlier, few of the homes we reviewed were or are part of CMS's Special Focus Facilities program. In 2005, only 2 were designated Special Focus Facilities and in 2006, the number increased to 4. Of the 8 homes that cycled in and out of compliance seven or more times (see fig. 3), 6 are still open but only 1 is now a Special Focus Facility. Although CMS now requires QIOs to work with poorly performing nursing homes, this initiative also only targets a small number of homes—as few as 1 to 3 facilities in each state.

To enhance its understanding of and ability to improve the enforcement process, CMS has funded two studies that will examine the steps that lead to sanctions as well as the impact of enforcement on homes' quality-of-care processes.

- **Qualitative Enforcement Case Studies.** This study, which began in the spring of 2003 and is scheduled to be completed in early 2007, required research nurses to visit 25 nursing homes in four states to evaluate how the survey and enforcement processes are carried out and assess the extent to which the enforcement process results in changes in nursing staff behavior and improved compliance with federal requirements.
- **Impact of Sanctions on Quality.** The objective of this study is to test the effects of sanctions on facility behavior and resident outcomes. Researchers will identify and compare a group of nursing homes that had both deficiencies and sanctions to a group of nursing homes that had similar levels of deficiencies but no sanctions. A year later, researchers will review the nursing home's subsequent survey to determine whether

⁸⁶In commenting on a draft of this report, Michigan noted that it recommends termination dates of less than 6 months for its Special Focus Facilities and has received support from the CMS regional office to do so. Michigan also noted that after one of its homes with a history of cycling in and out of compliance was designated a Special Focus Facility, the home's performance improved, and it will likely be removed from the Special Focus Facility list.

the sanctions resulted in any significant changes in the quality of care delivered. The study began in the fall of 2004 and the first report is scheduled to be completed by mid-2007.

Although CMS has taken several steps to improve its enforcement of nursing home requirements, its Nursing Home Compare Web site does not include information on sanctions. Thus, CMS does not indicate what sanctions have been implemented against nursing homes, nor does it identify homes that have received immediate sanctions for repeatedly harming residents.

As noted throughout this report, we found variation among the states we reviewed in areas such as the number and amount of CMPs implemented and the proportion of homes with double Gs. In general, these differences reflect the state survey agencies' views on the effectiveness of certain sanctions and differences in state enforcement policies. For example, Pennsylvania state officials prefer state rather than federal sanctions because they believe the former are more effective, have a greater deterrent effect on providers, and are easier and quicker to impose. Pennsylvania requires homes to pay a state CMP prior to appeal, even if the home appeals the deficiency. In contrast, homes need not pay a federal CMP until after an appeal is resolved. Pennsylvania rarely implemented federal CMPs on the 14 state homes whose compliance history we reviewed, preferring to use state sanctions instead. In Michigan, state officials are more likely to use federal CMPs and implement them in greater amounts than other states we reviewed. Texas state officials often use state rather than federal sanctions for G-level or higher deficiencies, in part because they cannot propose a federal CMP if they impose a state sanction and because the total state money penalty that may be imposed may be higher than federal CMPs. California had fewer sanctions than Michigan. California typically investigates complaints under its state licensure authority, which may partly explain why California has fewer reported deficiencies and federal sanctions. We believe it is important for CMS to explore the differences in state enforcement approaches and policies so that it can both identify problem areas and identify best practices that could be disseminated nationwide.

Conclusions

Although CMS has taken steps to strengthen the nursing home enforcement process, our review of 63 homes in four states with a history of quality problems identified design weaknesses as well as flaws in the way sanctions are implemented that diminish their full deterrent effect. Some of these homes repeatedly harmed residents over a 6-year period

and yet remain in the Medicare and Medicaid programs. Until these systemic weaknesses are addressed, the effectiveness of sanctions in encouraging homes to return to and maintain compliance will remain questionable and the safety and security of vulnerable residents will remain at risk.

CMS's immediate sanctions policy fails to hold homes with a long history of harming residents accountable for the poor care provided. The policy's complexity, such as the requirement for an intervening period of compliance, prevents its use for the very homes it was designed to address—those with systemic quality problems. Furthermore, the immediate sanctions label is misleading because sanctions are not, in fact, immediate. The notice period required by CMS regulations for sanctions such as DPNAs and terminations provides homes with a de facto grace period during which they can correct deficiencies to avoid an immediate sanction. Moreover, in one state we reviewed, the immediate sanctions policy does not fully identify all homes with repeat serious deficiencies because most complaint deficiencies, which can often trigger a double G, were being cited under state licensure authority, not federal. Consequently, some problem homes in the state were not identified by the policy and thus were able to avoid double G immediate sanctions.

Although CMPs and DPNAs were the most frequently used sanctions nationwide and for the homes we reviewed, their effectiveness was undermined by a number of weaknesses. The CMPs levied against the homes we reviewed were often nominal, significantly less than the maximum amounts Congress provided for in statute. To strengthen CMPs, CMS has been developing a CMP grid since 2004 to guide states and regional offices in determining appropriate CMP amounts, and CMS regional offices piloted the grid in 2006. However, its implementation is expected to be optional for states, once again contributing to interstate variation. Despite the nominal amounts, CMPs, unlike DPNAs, do not require a notice period and may be imposed retroactively before the date of the survey. However, these advantages are countered by the fact that, under the Social Security Act, payment by homes of federally imposed CMPs is deferred if they appeal their deficiencies, a process that can take years, diminishing the immediacy of the sanction and further undermining the sanction's deterrent effect. While there is precedent under the federal surface mining statute, which permits the collection of CMPs before exhaustion of appeals, it is unclear if the informal dispute resolution process available to nursing homes provides the same type of procedural safeguards that courts have pointed to in upholding the mining statute provision. Some states choose to use their own authority to impose state

fines, which can sometimes be implemented faster than is possible under federal law. Although CMS has the authority to implement discretionary DPNAs after a 15-day notice period for the homes we reviewed, it did not generally do so. It imposes mandatory DPNAs when criteria are met, which provide homes a 3-month de facto grace period to correct deficiencies. Because many homes we reviewed returned to compliance within 3 months—though often only temporarily—the DPNAs frequently were rescinded.

Termination—the most powerful enforcement tool—was used infrequently nationwide and for the homes we reviewed because of states’ and CMS’s concerns about potential access to care and resident transfer trauma. However, we found that some poorly performing homes are located in areas with several other nearby nursing homes. Even though some homes we reviewed cycled in and out of compliance numerous times while continuing to harm residents, CMS allowed them to determine for themselves whether and when to leave the Medicare and Medicaid programs. Even when terminations were imposed, their deterrent effect was undermined by extending some termination dates to give the homes more time to correct deficiencies. CMS’s earlier termination of such troubled homes could have cut short the cycle of poor care. CMS’s revamped Special Focus Facility program would provide for termination of poorly performing homes within 18 months if they fail to show significant improvement in the quality of care provided to residents. Despite the expansion of the program from about 100 to about 135 homes, the number of Special Focus Facilities is inadequate because, as our work has demonstrated, the program still fails to include many homes with a history of repeatedly harming residents.

Although CMS has made progress in establishing a database to help it track and monitor the nursing home enforcement process, the development of AEM is not yet complete. AEM is not integrated with other important databases to help ensure that CMS has a comprehensive picture of a home’s deficiency history, and CMS has not developed a concrete plan for using national enforcement reports—built off of AEM data—to help evaluate the effectiveness of sanctions and its enforcement policies. Having longitudinal enforcement data available for homes would enable CMS to pursue increasing the severity of sanctions for homes that repeatedly harm residents. Furthermore, CMS has not developed a system of quality checks to ensure the accuracy and integrity of AEM data.

CMS’s Nursing Home Compare Web site has been modified a number of times to add important quality information about nursing homes. While

CMS now summarizes the results from both standard surveys and complaint investigations, the Web site contains no information about sanctions implemented against nursing homes, nor does it identify homes that have received immediate sanctions for repeatedly harming residents. Such information could be valuable to consumers who use the Web site to help choose a home for family members or friends.

Recommendations for Executive Action

To address weaknesses that undermine the effectiveness of the immediate sanctions policy, we recommend that the Administrator of CMS reassess and revise the policy to ensure that it accomplishes the following three objectives: (1) reduce the lag time between citation of a double G and the implementation of a sanction, (2) prevent nursing homes that repeatedly harm residents or place them in immediate jeopardy from escaping sanctions, and (3) hold states accountable for reporting in federal data systems serious deficiencies identified during complaint investigations so that all complaint findings are considered in determining when immediate sanctions are warranted.

To strengthen the deterrent effect of available sanctions and to ensure that sanctions are used to their fullest potential, we recommend that the Administrator of CMS take the following three actions:

- Ensure the consistency of CMPs by issuing guidance such as the standardized CMP grid piloted during 2006.
- Increase use of discretionary DPNA's to help ensure the speedier implementation of appropriate sanctions.
- Strengthen the criteria for terminating homes with a history of serious, repeated noncompliance by limiting the extension of termination dates, increasing the use of discretionary terminations, and exploring alternative thresholds for termination, such as the cumulative duration of noncompliance.

To collect CMPs more expeditiously, which could increase their deterrent effect, we recommend that the Administrator of CMS develop an administrative process under which CMPs would be paid—or Medicare and Medicaid payments in equivalent amounts would be withheld—prior to exhaustion of appeals and seek legislation for the implementation of this process, as appropriate. Payments could be refunded with interest if the deficiencies are modified or overturned at appeal.

To strengthen sanctions for homes with a history of noncompliance, such as a large number of deficiencies or a large number of actual harm and immediate jeopardy deficiencies, we recommend that the Administrator of CMS consider further expanding the Special Focus Facility program with its enhanced enforcement requirements to include all homes that meet a threshold, established by CMS, to qualify as poorly performing homes.

To improve the effectiveness of its new enforcement data system, we recommend that the Administrator of CMS take the following three actions:

- Develop the enforcement-related data systems' abilities to interface with each other in order to improve the tracking and monitoring of enforcement, such as by developing an automatic interface between systems such as AEM and ACTS.
- Expedite the development of national enforcement reports, including longitudinal and trend reports designed to evaluate the effectiveness of sanctions and enforcement policies, and a concrete plan for using the reports.
- Develop and institute a system of quality checks to ensure the accuracy and integrity of AEM data, such as periodic data audits conducted as part of CMS's annual state performance reviews.

To improve public information available to consumers that helps them assess the quality of nursing home care, we recommend that the Administrator of CMS expand CMS's Nursing Home Compare Web site to include implemented sanctions, such as the amount of CMPs and the duration of DPNAs, and homes subjected to immediate sanctions.

Agency and State Comments and Our Evaluation

We obtained written comments on our draft report from CMS and three of the four states in which the homes we studied were located—California, Michigan, and Texas. We also received e-mail comments from the Director of the Division of Nursing Care Facilities in Pennsylvania. CMS's comments are reproduced in appendix VI. California's, Michigan's and Texas's comments are reproduced in appendixes VII, VIII, and IX, respectively. CMS generally concurred with our 12 recommendations in six areas intended to strengthen the enforcement process but did not always specify how it would implement the recommendations. In addition, CMS noted that implementation of 3 of our recommendations raised resource issues and that others required additional research. California

concluded with our conclusions and recommendations, while Michigan and Pennsylvania indicated appreciation or general agreement. However, most state comments, including Texas's, were technical in nature. Our evaluation responds to CMS and state comments in the six areas covered by our recommendations.

Addressing weaknesses in the double G immediate sanctions policy.

CMS agreed that homes that repeatedly harm residents should not escape immediate sanctions and stated that it would remove the limitation on applying an additional sanction when a home failed to correct a deficiency that gave rise to a prior sanction. CMS also agreed to reduce the lag time between citation and implementation of a double G immediate sanction by limiting the prospective effective date for DPNAs to no more than 30 to 60 days. Reducing the lag time as much as possible is critical because it provides homes with a de facto grace period in which to correct deficiencies and avoid sanctions. Michigan commented about the need to increase the immediacy of DPNAs, noting that even the 15-day notice period associated with discretionary DPNAs was outdated now that homes are notified electronically and delivery can be verified. Currently, CMS has an incomplete picture of serious deficiencies cited against homes that could result in immediate sanctions because California investigates many nursing home complaints under state licensure authority. CMS agreed to collect additional information on complaints for which data are not reported in federal data systems. We believe that CMS's commitment to do this will help better identify and deal with consistently poorly performing homes. CMS commented that the Social Security Act does not provide authority for CMS to require states to report enforcement actions taken under state-only authority if federal resources are not used for the complaint investigation; however, to the extent that federal funds are used for complaint investigations, our findings and recommendations remain valid. Michigan concurred that CMS needs the complete compliance history of a facility to assess its overall performance.

CMS acknowledged that the complexity of its immediate sanctions policy may be an inherent limitation and indicated that it intends to either strengthen the policy or replace it with a policy that achieves similar goals through alternative methods. CMS noted that it is concerned about whether the immediate sanctions policy has negatively affected the rates of state deficiency citations and may ultimately be ineffective with the most problematic facilities. We believe the policy has merit but that its complex requirements have prevented many homes from receiving immediate sanctions.

Strengthening the deterrent effect of sanctions. CMS agreed to issue a CMP analytic tool, or grid, and to provide states with further guidance on discretionary DPNAs and terminations. The CMP grid is a tool to help ensure national consistency in CMPs and to assist CMS regional offices in monitoring enforcement actions. Texas commented that it had been using the grid since June 2006 and found it to be very helpful. Michigan noted that it had independently developed and implemented a CMP grid in 2000 but expressed disappointment that CMS had not mandated state use of the agency's grid. In addition, Michigan supported the need for additional CMS guidance on the use of discretionary termination. Such guidance, it commented, was necessary to ensure a consistent national approach. In response to our recommendation to increase the use of discretionary terminations, CMS stated that it will continue its research to design proposals that yield a more effective combination of robust enforcement actions but that do not penalize vulnerable residents. While we encourage CMS's commitment to further research to improve the effectiveness of enforcement actions, we believe that CMS must also be committed to protecting residents from actual harm in poorly performing facilities—including terminating homes from the Medicare or Medicaid programs—when other steps fail to ensure the quality of resident care.

Collecting CMPs more expeditiously. CMS agreed to seek legislative authority to collect CMPs prior to the exhaustion of appeals, which could increase their deterrent effect. California commented that it supported this recommendation.

Expanding the Special Focus Facility program. CMS agreed with the concept of expanding the program to include all homes that meet a threshold to qualify as poorly performing homes, but said it lacks the resources needed for this expansion because of decreases in its budget and increases in both the number of providers and quality assurance responsibilities for state and federal surveyors. CMS stated that it envisioned expansion of the program if Congress fully funds the President's proposed fiscal year 2008 budget for survey and certification activities. CMS specified other initiatives it will implement to improve the Special Focus Facility program.

Improving the effectiveness of enforcement data. CMS agreed to develop and implement a system of quality checks to ensure the accuracy of its data systems, including AEM. While the agency agreed to study the feasibility of linking the separate data systems used for enforcement and to develop other national standard enforcement reports, CMS indicated that available resources may limit its ability to take further action on these

issues. CMS has already invested significant resources in developing potentially powerful data systems intended to improve the tracking and monitoring of enforcement, and we believe the agency should place a priority on ensuring that these systems operate effectively.

Improving information available to consumers. Rather than agreeing to report all implemented sanctions on its Nursing Home Compare Web site, CMS proposed reporting implemented sanctions only for poorly performing homes that meet an undefined threshold. CMS's response was therefore not fully responsive to our recommendation. By only reporting sanctions for homes that meet a certain threshold—eight or more sanctions in a 3-year period, in an example provided by CMS—consumers might incorrectly assume that other homes have received no sanctions. Furthermore, CMS's plan to post such limited sanctions data in an accessible location on its Web site is vague. We believe that consumers must be able to easily link deficiency and sanctions data.

CMS and three of the four states also provided technical comments, which we incorporated as appropriate.

As arranged with your office, 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 the GAO Web site at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-7118 or allenk@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 X.

Sincerely yours,



Kathryn G. Allen
Director, Health Care

Appendix I: Scope and Methodology

This appendix provides a more detailed description of our scope and methodology and generally follows the order that findings appear in the report. We analyzed the fiscal years 2000 through 2005 enforcement and deficiency history for a total of 63 of the 74 nursing homes in four states—California, Michigan, Pennsylvania, and Texas—whose compliance history informed the conclusions of our March 1999 report.¹ These homes had a history of providing poor quality care to residents prior to 1999. We excluded 11 of the original 74 homes from our analysis because they either closed before fiscal year 2000 or closed within 6 months of the beginning of fiscal year 2000 and had few or no deficiencies or sanctions.² Some of the remaining 63 homes participated in the Medicare and Medicaid programs for only a portion of fiscal years 2000 through 2005 because they either closed permanently or closed temporarily and were subsequently reinstated. For these homes, we set a criterion that required that the home participate for at least 6 months of the fiscal year in order for its enforcement data in that fiscal year to be included in our analysis. Table 8 shows the distribution of homes across the four states in our 1999 report, the distribution of those homes for this report, and the number of providers participating for at least 6 months by fiscal year. Although the table shows some year-to-year fluctuation in the number of providers, the changes do not significantly influence our findings. While the focus of our analysis was the compliance history of these 63 homes, we also analyzed general trends in (1) implemented sanctions nationwide for the same 6-year period and (2) the proportion of homes in each state cited for serious deficiencies—that is, those at the actual harm or immediate jeopardy level.

¹See [GAO/HEHS-99-46](#). Because the homes reviewed for this report were selected based on their poor compliance histories, the findings of this report cannot be generalized to nursing homes in the states in which the homes are located or to nursing homes nationwide. However, we believe that the findings of this report illustrate the adequacy of federal and state sanctions taken against homes with histories of providing poor quality care to residents.

²Of the 11 original 74 homes we excluded, CMS involuntarily terminated 5, and 6 closed voluntarily.

Table 8: Number of Nursing Homes Reviewed in 1999 That Were Included in Our Analysis for This Report, by State

State	1999 report	Current report						
		Any participation in fiscal years 2000-2005	2000	2001	2002	2003	2004	2005
California	12	10	10	10	10	10	10	10
Michigan	18	16	14	14	13	13	12	13
Pennsylvania	17	14	14	13	13	12	10	10
Texas	27	23	23	22	22	23	22	22
Total	74	63	61	59	58	58	54	55

Source: GAO.

CMS deficiency data. To determine the number, scope, and severity of deficiencies cited for the 63 homes, we analyzed OSCAR (On-Line Survey, Certification, and Reporting system) deficiency data resulting from standard surveys and complaint investigations. We also used OSCAR data on deficiencies identified during standard surveys to analyze state trends in the proportion of nursing homes cited for actual harm or immediate jeopardy during fiscal years 2000 through 2005. Because a home may be surveyed more than once a year, we counted a home only once if it was cited for actual harm or immediate jeopardy on more than one survey during the year. CMS officials generally recognize OSCAR data to be reliable. We have used OSCAR data in our prior work to examine nursing home quality.

CMS enforcement data and reliability issues. Because CMS used multiple data systems during the 6-year period we reviewed and because of data reliability issues, such as incomplete or inaccurate data, we used several sources to validate and analyze the enforcement history of the 63 homes. Based on discussions with CMS regional staff who were responsible for inputting the data, our primary data source for homes in California, Michigan, and Pennsylvania for the period fiscal years 2000 through 2004 was the Long Term Care Enforcement Tracking System (LTC).³ Because CMS’s Dallas regional office expressed concern about reliability of LTC data in the region, we relied primarily on regional office and state enforcement case files for the Texas homes we reviewed. CMS phased out use of LTC at the end of fiscal year 2004 and began using Aspen Enforcement Manager (AEM) to track sanctions. We obtained data

³We obtained the data from CMS on July 26, 2005.

for fiscal year 2005 sanctions from the limited AEM data stored in the OSCAR enforcement file. To clarify data from LTC or AEM and to perform some basic data checks, we relied on regional office and state enforcement case files and made adjustments as appropriate. We discussed the reliability of LTC and AEM enforcement data with CMS and state survey agency officials. CMS informed us that the data generally were reliable. We determined that the data were sufficiently reliable to assess broad trends in implemented sanctions nationwide, and to analyze sanctions among the 63 homes we reviewed because we could conduct checks of the homes' enforcement data using CMS regional office and state case files. Because we could not conduct such checks of the data in all 50 states and the District of Columbia, we did not analyze trends across the individual states.

Trends in sanctions. Based on our assessment of data reliability, we determined that we could assess broad trends in implemented sanctions nationwide, but because we could not conduct checks of the data in all 50 states and the District of Columbia, we did not analyze trends across the states. For the homes we reviewed, using data from LTC, AEM, and regional office and state enforcement case files as described above, we analyzed the number of civil money penalties (CMP), denial of payments for new admissions (DPNA), and terminations implemented over two 3-year time periods—fiscal years 2000 through 2002 and fiscal years 2003 through 2005. We aggregated sanctions into fiscal years on the basis of their implementation dates. To determine the duration of DPNAs across the two time periods, we calculated the difference between the effective dates and the end of the DPNAs. To determine the amount of CMPs paid, we used the CMP Tracking System (CMPTS), a CMS financial management system,⁴ and aggregated CMPs into fiscal years according to the year in which they were implemented. Based on discussions with CMS officials we determined that data in CMPTS are generally reliable. They also stated that the system is the primary system used by CMS for the collection of CMPs and is the only source for CMP payment data used by CMS. We matched CMP data in LTC and CMPTS based on their collection number. For fiscal year 2005, we relied on regional enforcement files for the amount of paid CMPs.

⁴We received CMPTS data from CMS on April 21, 2006.

Implementation rate of sanctions. We determined the implementation rate of sanctions imposed for the homes we reviewed in fiscal years 2000 through 2005. The percentage of implemented sanctions was calculated by dividing the number of implemented sanctions by the total number of imposed sanctions. The total number of imposed sanctions included those that were implemented, not implemented, and were pending. We used data from our March 1999 report on imposed and implemented sanctions for the period July 1995 through October 1998.⁵

Range of sanctions. CMS enforcement data allowed us to differentiate between per day and per instance CMPs and mandatory and discretionary DPNAs and terminations. We counted the number of sanctions by type and aggregated the number by fiscal year based on the date of implementation. The data provided the value of per day and per instance CMPs, which were used to calculate the median values of CMPs across the two time periods—fiscal years 2000 through 2002 and 2003 through 2005.

Cycling in and out of compliance. We analyzed the enforcement data from LTC, AEM, and CMS regional office and state records to determine if the 63 homes we reviewed cycled in and out of compliance from fiscal years 2000 through 2005. To determine the number of times homes cycled in and out of compliance, we counted the number of noncompliance cycles recorded for the 63 homes. A noncompliance cycle begins on the date of the survey finding noncompliance and ends when the home has achieved substantial compliance by correcting deficiencies. For noncompliance cycles for which sanctions were implemented, we examined survey dates, the date substantial compliance was achieved, and the sanctions that were implemented as a result of the deficiencies cited. To determine how quickly homes were again noncompliant, we calculated the difference between the date of the first survey of the subsequent noncompliance cycle and the substantial compliance date of the preceding noncompliance cycle. To quantify the number of noncompliance cycles during which actual harm occurred, we assessed whether homes were cited for G-level or higher deficiencies on the surveys within the noncompliance cycle.

Immediate sanctions policy. We identified instances in which the 63 homes we reviewed were cited for repeatedly harming residents to determine if immediate sanctions were imposed and their effect on

⁵See [GAO/HEHS-99-46](#).

detering subsequent noncompliance. To identify sanctions imposed as a result of the immediate sanctions policy, we first identified homes that qualified for immediate sanctions using CMS's Providing Data Quickly (PDQ) system which prepares a variety of reports using survey and certification data. CMS officials indicate that the data in Providing Data Quickly are generally recognized as reliable. We then matched the survey date in Providing Data Quickly with the survey date in the enforcement data to identify the noncompliance cycle during which qualifying deficiencies were cited.⁶ This step enabled us to identify the sanctions imposed. We reviewed each case individually to verify that the sanction was the result of actual harm or higher-level deficiencies that denied the home an opportunity-to-correct period or simply resulted from another survey in the same noncompliance cycle. We also compared the date of survey with the imposition and effective dates of sanctions to assess how much time passed between identification of the deficiency that led to the immediate sanction and the imposition and implementation of the sanction. During the course of our work, we also discussed the rationale behind the specific formulation of the immediate sanctions policy with CMS officials.

⁶In a small number of cases, the survey date recorded in PDQ did not match the survey date in the enforcement data. Mismatches generally occurred because the survey date in PDQ erroneously reflected another survey, usually the first of the noncompliance cycle, even if there was no G-level or higher deficiency on that survey, rather than the survey on which the G-level or higher deficiency was cited. After consulting with CMS, we adjusted the survey dates to reflect the correct dates.

Appendix II: Percentage of Nursing Homes Cited for Actual Harm or Immediate Jeopardy, by State, Fiscal Years 2000-2005

In order to identify trends in the proportion of nursing homes cited with actual harm or immediate jeopardy deficiencies, we analyzed data from CMS's OSCAR database for fiscal years 2000 through 2005 (see table 9). Because surveys are conducted at least every 15 months (with a required 12-month statewide average), it is possible that a home was surveyed twice in any time period. If a home was cited for a G-level or higher deficiency on more than one survey during the fiscal year, we only counted it once.

Table 9: Percentage of Nursing Homes Cited for Actual Harm or Immediate Jeopardy during Standard Surveys, Fiscal Years 2000-2005

State	Number of homes, 2005 ^a	Fiscal year					
		2000	2001	2002	2003	2004	2005
Alabama	229	35.5	23.0	12.7	18.1	15.6	23.1
Alaska	14	28.6	26.7	26.7	0.0	0.0	0.0
Arizona	135	24.2	12.6	7.3	6.6	9.4	9.9
Arkansas	245	38.1	27.7	22.3	24.7	19.5	15.9
California	1,329	24.1	10.9	5.1	3.7	6.1	8.0
Colorado	215	20.4	26.4	32.7	20.9	25.9	40.4
Connecticut	247	41.9	51.6	45.8	43.1	54.4	44.2
Delaware	42	47.5	14.6	10.8	5.3	15.0	35.7
District of Columbia	20	17.7	28.6	30.0	41.2	40.0	30.0
Florida	691	22.8	20.2	14.9	10.2	7.8	4.2
Georgia	370	19.5	21.0	23.7	24.6	16.6	18.0
Hawaii	45	23.8	14.3	21.2	12.1	22.9	2.8
Idaho	81	51.4	29.7	39.2	31.9	27.3	38.4
Illinois	836	28.4	19.2	15.3	18.3	15.1	15.7
Indiana	518	45.0	29.4	23.2	19.7	24.1	28.3
Iowa	465	14.7	12.0	8.0	9.1	11.8	11.2
Kansas	374	37.9	30.7	32.9	26.5	30.3	34.9
Kentucky	297	26.8	29.1	23.2	26.1	14.6	7.7
Louisiana	321	21.8	29.9	21.7	16.2	12.0	15.4
Maine	116	11.1	13.9	6.6	11.1	12.8	7.0
Maryland	239	22.4	16.5	26.1	15.4	17.8	7.6
Massachusetts	466	29.1	24.4	24.6	25.9	16.7	22.6
Michigan	432	42.8	24.5	29.7	26.9	22.9	22.9
Minnesota	411	30.4	17.3	22.3	18.3	14.3	14.4
Mississippi	210	33.0	19.8	18.7	16.0	18.9	18.1

**Appendix II: Percentage of Nursing Homes
Cited for Actual Harm or Immediate
Jeopardy, by State, Fiscal Years 2000-2005**

State	Number of homes, 2005 ^a	Fiscal year					
		2000	2001	2002	2003	2004	2005
Missouri	532	19.8	13.0	15.6	12.5	11.7	15.4
Montana	100	33.3	29.7	12.0	20.0	18.0	17.9
Nebraska	235	19.2	21.1	20.1	14.8	15.3	14.4
Nevada	47	34.8	14.6	11.9	9.1	17.5	19.6
New Hampshire	82	37.8	31.1	29.4	24.1	25.6	26.3
New Jersey	364	25.5	27.8	18.8	10.5	13.5	18.2
New Mexico	77	23.7	16.9	14.9	21.3	24.3	29.4
New York	662	33.8	37.1	34.2	15.2	11.0	14.0
North Carolina	426	43.6	35.8	25.6	29.0	21.1	18.5
North Dakota	83	25.9	28.7	17.9	12.4	13.6	17.7
Ohio	993	26.6	27.3	25.4	19.1	11.4	13.8
Oklahoma	387	19.3	21.3	22.0	26.3	13.9	23.2
Oregon	139	45.5	32.6	23.7	20.3	15.9	19.8
Pennsylvania	727	30.3	19.2	13.5	17.2	19.5	15.2
Rhode Island	92	14.3	12.9	5.6	6.7	9.3	9.5
South Carolina	177	26.4	17.2	19.8	29.6	32.7	24.8
South Dakota	112	27.1	26.7	26.8	32.1	21.6	12.8
Tennessee	337	28.2	20.2	20.7	21.8	22.9	17.3
Texas	1,174	29.7	30.5	22.4	18.0	12.0	16.2
Utah	93	19.5	14.1	25.6	19.0	11.1	8.4
Vermont	41	22.5	18.2	15.0	10.0	19.5	23.7
Virginia	281	19.2	14.3	11.6	13.7	10.2	15.5
Washington	251	46.9	38.3	37.0	30.9	28.1	27.2
West Virginia	133	12.1	17.7	20.4	12.7	9.8	15.0
Wisconsin	405	15.8	15.6	11.2	10.9	13.1	18.2
Wyoming	39	52.8	32.4	25.0	22.9	17.1	11.8
Nation	16,337	28.4	23.3	20.2	17.8	15.7	16.8

Source: GAO analysis of OSCAR and PDO data.

^aThese numbers illustrate the significant variation in the number of active nursing homes across states.

Appendix III: Federal Sanctions for Nursing Homes Reviewed, by State, Fiscal Years 2000-2005

Table 10 provides the number of CMPs, DPNAs, and terminations implemented in the nursing homes we reviewed, by state for fiscal years 2000-2002 and fiscal years 2003-2005. It also provides the total amount of CMPs paid and the total duration of DPNAs implemented during the two time periods. The total amount of CMPs payable in the fiscal years may differ from what was paid.

Table 10: Number of Sanctions Implemented Among Homes We Reviewed, Fiscal Years 2000-2005

State	Sanction	FY 2000-2002		FY 2003-2005		Percentage change in number from first to second time period	
		Average number of homes reviewed	Number ^a	Average number of homes reviewed	Number ^a		
California		10		10			
	CMP ^b		5		7	40%	
	DPNA ^c		4	155 days	3	189 days	-25%
	Involuntary termination ^d		0	NA	0	NA	NA
Michigan		14		13			
	CMP ^b		40	\$186,313	35	\$419,401	-13%
	DPNA ^c		26	1,206 days	19	796 days	-27%
	Involuntary termination ^d		0	NA	1	NA	100%
Pennsylvania		13		11			
	CMP ^b		7	\$62,400	1	\$0	-86%
	DPNA ^c		9	499 days	5	181 days	-44%
	Involuntary termination ^d		0	NA	0	NA	NA
Texas		22		22			
	CMP ^b		41	\$176,420	11	\$31,671	-73%
	DPNA ^c		13	591 days	3	79 days	-77%
	Involuntary termination ^d		1 ^e	NA	0	NA	-100%

Source: GAO analysis of LTC, OSCAR, CMS regional office and state enforcement case files, and CMPTS.

Note: Includes sanctions data from LTC as of July 26, 2005; OSCAR as of November 22, 2005; CMS regional office and state enforcement case files; and CMPTS data as of April 21, 2006.

NA = not applicable.

^aNumber of sanctions implemented in the time period.

^bIncludes per day and per instance CMPs.

^cIncludes mandatory and discretionary DPNAs.

**Appendix III: Federal Sanctions for Nursing
Homes Reviewed, by State, Fiscal Years
2000-2005**

⁴Includes mandatory and discretionary involuntary terminations.

⁸Although the home did not participate for 6 months of fiscal year 2001 because it was involuntarily terminated in February 2001, the involuntary termination is counted because involuntary termination is the most severe sanction and because it occurs so infrequently.

Appendix IV: Examples of Homes Reviewed That Frequently Cycled In and Out of Compliance

This appendix provides additional examples of the compliance history of homes we reviewed that frequently cycled in and out of compliance (see table 6). The table also includes examples of the nature of the deficiencies cited in each noncompliance period. The three homes in table 11 were cited for serious deficiencies—those at the actual harm or immediate jeopardy level—and corrected these deficiencies only temporarily, despite receiving sanctions; on subsequent surveys, they were again found to be out of compliance, sometimes for the same deficiencies. A noncompliance period begins on the first day a survey finds noncompliance and ends when a home both corrects the deficiencies and achieves substantial compliance or the home is terminated from Medicare and Medicaid. Only federal sanctions that were imposed and implemented are included in the table.

Table 11: Examples of Homes that Frequently Cycled In and Out of Compliance

Noncompliance period (no. of days)	Examples of the nature of deficiencies ^a	Summary of G-level or higher deficiencies	Enforcement action implemented ^b
California home^c			
1 st (84 days)	<ul style="list-style-type: none"> Resident abuse Poor quality of care 	10 G	<ul style="list-style-type: none"> Per day CMP (\$500/day) Discretionary DPNA (42 days)
2 nd (131 days)	<ul style="list-style-type: none"> Inadequate treatment or prevention of pressure sores Poor quality of care 	1 G	<ul style="list-style-type: none"> Per day CMP (\$100/day) Discretionary DPNA (13 days)
3 rd (126 days)	<ul style="list-style-type: none"> Resident abuse Inadequate treatment or prevention of pressure sores 	2 G, 3 H	<ul style="list-style-type: none"> 1st per day CMP (\$3,000/day) 2nd per day CMP (\$500/day) Discretionary DPNA (87 days)
4 th (181 days)	<ul style="list-style-type: none"> Resident abuse 	3 G	<ul style="list-style-type: none"> Per instance CMPs (3 at \$1,500/each) Discretionary DPNA (89 days)
Pennsylvania home^d			
1 st (204 days)	<ul style="list-style-type: none"> Inadequate treatment or prevention of pressure sores Poor accident supervision or prevention 	17 G	<ul style="list-style-type: none"> Per day CMP (\$1,000/day) Mandatory DPNA (74 days)
2 nd (147 days)	<ul style="list-style-type: none"> Employing convicted abusers Inadequate treatment of incontinence or unnecessary use of catheters 	1 G	<ul style="list-style-type: none"> Per instance CMP (\$10,000) Mandatory DPNA (12 days)
3 rd (188 days)	<ul style="list-style-type: none"> Employing convicted abusers Medication errors 	1 G	<ul style="list-style-type: none"> Mandatory DPNA (82 days)
4 th (140 days)	<ul style="list-style-type: none"> Poor nutrition Poor accident supervision or prevention 	2 H	<ul style="list-style-type: none"> Discretionary DPNA (61 days)

**Appendix IV: Examples of Homes Reviewed
That Frequently Cycled In and Out of
Compliance**

Noncompliance period (no. of days)	Examples of the nature of deficiencies^a	Summary of G-level or higher deficiencies	Enforcement action implemented^b
Texas home^c			
1 st (105 days)	<ul style="list-style-type: none"> Staff mistreatment of residents Inadequate treatment or prevention of pressure sores Use of unnecessary drugs 	4 G	<ul style="list-style-type: none"> 1st per instance CMP (\$6,000) 2nd per instance CMP (\$2,500)
2 nd (1 day)	<ul style="list-style-type: none"> Staff mistreatment of residents Employing convicted abusers 	1 K	<ul style="list-style-type: none"> 1st per day CMP (\$3,050/day) 2nd per day CMP (\$750/day)
3 rd (11 days)	<ul style="list-style-type: none"> Resident abuse Employing convicted abusers 	1 G, 1 J	<ul style="list-style-type: none"> Per day CMP (\$1,000/day)
4 th (147 days)	<ul style="list-style-type: none"> Medication errors Employing convicted abusers 	8 G, 2 H	<ul style="list-style-type: none"> 1st per day CMP (\$3,050/day) 2nd per day CMP (\$400/day) 3rd per day CMP (\$300/day) 4th per day CMP (\$50/day) Discretionary DPNA (141 days)
5 th (19 days)	<ul style="list-style-type: none"> Inadequate treatment or prevention of pressure sores Accident hazards 	1 G	<ul style="list-style-type: none"> Per day CMP (\$500/day)
6 th (98 days)	<ul style="list-style-type: none"> Poor nutrition Employing convicted abusers Poor quality of care 	2 G, 1 K	<ul style="list-style-type: none"> 1st per day CMP (\$3,050/day) 2nd per day CMP (\$750/day) 3rd per day CMP (\$50/day) 4th per day CMP (\$500/day) Discretionary DPNA (67 days)
7 th (52 days)	<ul style="list-style-type: none"> Poor nutrition 	0 G-level or higher; 1 E, 2 F	<ul style="list-style-type: none"> Per day CMP (\$50/day) Discretionary DPNA (20 days)
8 th (19 days)	<ul style="list-style-type: none"> Home failed to provide necessary services for daily living Employing convicted abusers 	4 K	<ul style="list-style-type: none"> Per instance CMP (\$10,000)
9 th (1 days)	<ul style="list-style-type: none"> Poor quality of care 	1 G	<ul style="list-style-type: none"> Per instance CMP (\$5,000)
10 th (5 days)	<ul style="list-style-type: none"> Poor nutrition 	0 G-level or higher; 1 E, 2 F	<ul style="list-style-type: none"> Per day CMP (\$500/day)

Source: GAO analysis of LTC, OSCAR, and CMS regional office and state enforcement case files.

Notes: Enforcement actions listed were federal sanctions imposed and implemented (sanctions imposed but not implemented and state sanctions are not included). The total number of D-level or higher deficiencies includes all deficiencies—not just the deficiencies that occurred during the noncompliance cycles cited—for the period fiscal years 2000 through 2005.

^aExamples of the nature of deficiencies include D-level or higher deficiencies.

^bIn a number of cases, there is more than one per day CMP listed as an enforcement action because CMPs can be raised or lowered based on changes in deficiencies.

^cHome open as of November 2006.

^dHome closed in January 2004.

^eHome closed in January 2004.

Appendix V: Number of Days between Survey and Implementation Date of DPNA for Homes Reviewed, Fiscal Years 2000-2005

Days	Number of DPNAs	Percentage of total
<0 days	1	4
1-15 days	3	12
16-30 days	4	16
31-60 days	15	60
61-90 days	1	4
More than 90 days	1	4

Source: GAO analysis.

Notes: This analysis only includes DPNAs for which survey and implementation dates were available. DPNAs implemented less than 15 days from the date of the survey were for deficiencies cited in a prior survey; in these cases, CMS continued the DPNA as the sanction for the current deficiencies.

Appendix VI: Comments from the Centers for Medicare & Medicaid Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

FEB 20 2007

TO: Kathryn G. Allen
Director, Health Care
Government Accountability Office

FROM: Leslie V. Norwalk, Esq.
Acting Administrator 

SUBJECT: Government Accountability Office (GAO) Draft Report: "Nursing Homes: Efforts to Strengthen Federal Enforcement Have Not Deterred Some Homes from Repeatedly Harming Residents" (GAO-07-241)

Thank you for the opportunity to comment on the above report. The report was prepared at the request of the Senate Finance Committee "to assess CMS' progress in improving the enforcement process, particularly for homes with a history of harming residents." The report makes a number of recommendations for the Centers for Medicare & Medicaid Services' (CMS) consideration:

1. Strengthen the immediate sanctions policy for facilities with a history of resident harm;
2. Strengthen the deterrent effect of sanctions;
3. Seek legislation to authorize collection of civil monetary penalties, as appropriate;
4. Expand CMS oversight of homes with a history of harming residents;
5. Improve the effectiveness of CMS enforcement data systems; and
6. Improve information available to consumers regarding sanctions that have been applied.

In recent years CMS has devoted increasing effort to strengthening enforcement of the quality of care requirements specified in regulation and law for nursing homes. Examples include:

- **"Double G Policy":** In 2000 we implemented faster and progressively stronger sanctions for those nursing homes in which residents have been repeatedly harmed. This "double G" policy makes greater use of immediate sanctions, such as civil monetary penalties (CMPs), Denial of Payment for New Admissions (DPNAs), and Termination of the Provider Agreements (TPAs) to strengthen the deterrent effect of sanctions.
- **Special Focus Facilities (SFF):** A subset of those nursing homes with the worst quality of care records are now surveyed with twice the frequency of other nursing homes and subject to decisive action if significant improvements are not made.
- **Complaint Tracking System:** In 2004 we implemented a national, electronic tracking system for complaints and follow-through on complaint investigations (the Aspen Complaint Tracking System, or "ACTS").

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- **Enforcement Tracking System:** In 2005 we implemented a national, electronic system for tracking and managing enforcement actions (Aspen Enforcement Manager, or "AEM").
- **Studies of Enforcement Effectiveness:** We initiated two special studies to help guide the development of further efforts to strengthen enforcement effectiveness. We expect results to be available in 2007.
- **Leadership Summit:** The CMS Leadership Summit with State Survey Agency (SA) directors will be held in April 2007 and is primarily focused on the issue of improving enforcement effectiveness.

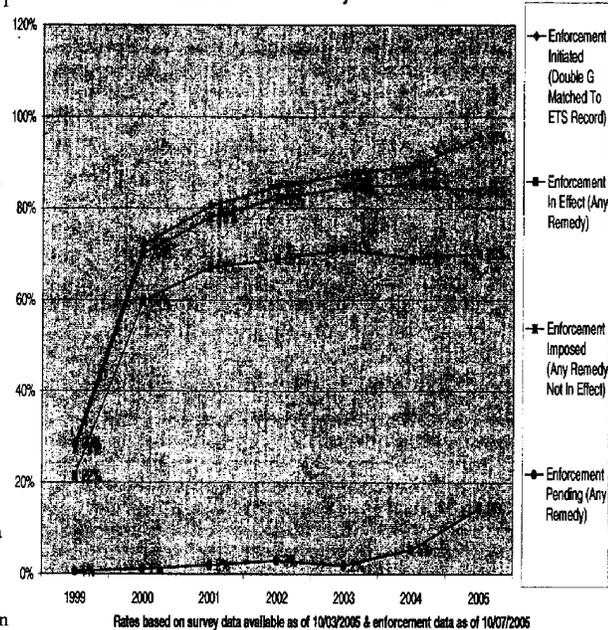
The GAO report focuses particularly on the "double G" (actual harm) policy and the extent to which enforcement action is applied - and applied quickly - when a nursing home has two or more instances in which consecutive surveys find that harm has occurred to residents. To put the issue in context, Figure 1 shows the national trend of enforcement action over time for the "double G" policy.

The top line shows the percent of such nursing homes in which an enforcement action (CMP or DPNA) was initiated. The percentage increased from 29 percent in 1999 to 72 percent in 2000, showing the effect of the new policy. Consistent CMS and State attention to the policy resulted in a 96 percent initiation rate in 2005.

The second line shows a similar trend in the percentage of such nursing homes in which the initiated action was imposed. The third line shows the percentage of sanctions that actually took effect.

The main reason some sanctions do not take effect is that the nursing home may have fixed the deficiency before the sanction's effective date, usually a DPNA that must be provided with

Fig. 1 - Percent of Medicare-Participating Double G's With Enforcement Action - By Calendar Year



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advance notice. We expect that the percentage having taken effect for 2005 will be greater than the 84 percent currently documented, once court action and other appeals are completed for the 14 percent of cases whose disposition is still pending (see bottom line of the graph).

As the GAO notes, it is also important to promote national consistency in the application of remedial action. CMS has continued to work with States to reduce any inconsistencies. The following graph, for example, shows the narrowing difference between regions in the extent to which enforcement action is initiated upon a survey finding that consecutive actual harm ("double G") has occurred. For each year from 2000 through 2005, the top line of figure 2 shows the percentage of such cases for States in the CMS regions with the highest compliance rate, compared with the average for States in the regions with the lowest compliance rate. The disparity was consistently reduced from a high of 61 percentage points in 2000 (87 percent v. 26 percent) to 22 percentage points in 2005 (99 percent v. 77 percent).

While CMS and State application of existing sanctions is important, other important questions are:

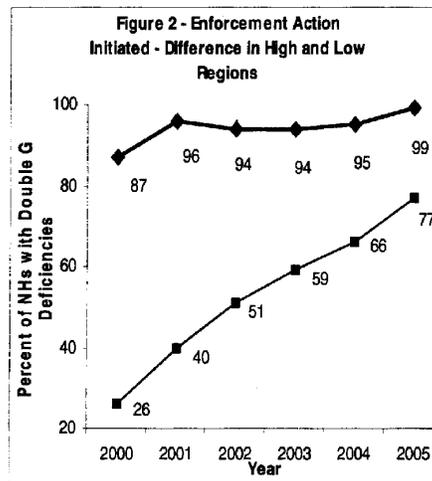
1. Why do some nursing homes improve and others do not?
2. What array of enforcement and ancillary actions is most effective in changing the odds that poorly performing nursing homes will improve and maintain compliance with federal quality requirements?

These questions guide our responses to the GAO recommendations. We wish to levy sanctions not for the sake of levying sanctions per se, but to ensure enduring improvement and the high quality of care that residents deserve. In some cases this may mean that our policies ought to be changed rather

than enforced in their current form. In other cases an excellent policy may simply need to await the availability of adequate resources. *Attachment One* contains an itemization of our actions in reference to each GAO recommendation. Our remarks below focus on just a few of the more significant issues on which we have a difference in perspective compared to the GAO.

Double G Policy Itself

We will either strengthen the "double G" policy or replace it with a policy that will achieve similar goals through alternate methods. As the GAO notes, the policy itself is quite complex. Such complexity may be an inherent limitation. We also have other concerns regarding whether the policy has had negative effects on the rates of deficiency findings, and we continue to study this



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issue. Any fundamental change will await our further deliberations regarding the feasibility of any substitutes.

We believe that additional actions may be warranted, including the involvement of owners and boards of directors more closely in the remediation process. The GAO analysis is based on the implicit assumption that 100 percent implementation of the double G policy in all cases will yield measurably different results. Yet, with regard to the sample of nursing homes in their study, the GAO also observes that "Two-thirds (18) of the 27 nursing homes cited for double Gs that subsequently had sanctions implemented went on to be cited again for one or more additional double Gs¹." In such cases, the issue clearly is not one of CMS or State implementation. Instead there is a question about the policy's ultimate effectiveness with the most problematic facilities.

For many nursing homes with a history of serious and chronic poor quality, more CMPs or similar sanctions may simply not be very effective. At the extreme end of the enforcement spectrum, a policy of widespread termination of provider agreements for such nursing homes would mean that a very large number of nursing home residents would lose their residence. The question remains as to whether there is a more effective combination of robust enforcement actions that is effective for seriously-underperforming nursing homes and which does not penalize vulnerable residents for the failures of nursing home management. These are some of the questions behind our continuing research and deliberations.

Special Focus Facilities (SFF)

In the SFF, a subset of those nursing homes with the worst quality of care records are surveyed with twice the frequency of other nursing homes and subject to decisive action if significant improvements are not made. The GAO recommended that we expand and strengthen the SFF initiative. We believe that this initiative is very important and will offer vital information that will guide broader policy. We will track the trajectory of such nursing facilities and develop some case studies that may also be helpful in answering the question of why some nursing homes improve and others do not. We will also improve the policy by ensuring that all responsible parties – including the boards of directors and the owners - are fully informed at the outset regarding the seriousness of the facility's deficiencies, the seriousness of CMS enforcement actions, and the imperative for improvement.

At the current time we must regretfully refrain from endorsing GAO's suggestion that we expand the number of nursing homes in the SFF initiative. Such expansion requires added resources, since SFF facilities have twice the number of onsite surveys as other nursing homes. We did expand the number by 35 percent in 2005, the last time that Congress increased the Medicare budget for survey and certification. Three factors combine to impede further quality assurance efforts:

- **National S&C Budget:** Since 2003, there has been only one increase in survey and certification budget, and the 1 year of increase (2005) was \$11.7 million below the President's budget request. A flat-line budget for 2007 will leave the national budget lower than in 2005 and about \$25 million (12 percent) below the President's proposed 2007 level.

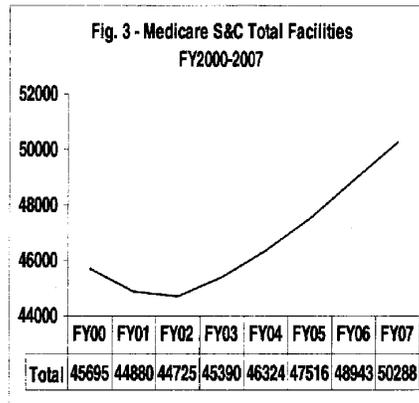
¹ Page 30, draft report, GAO-07-241 Nursing Home Enforcement

Now on p. 35.

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- **More Providers:** The total number of providers that participate in Medicare and/or Medicaid continues to increase. This trend enlarges the overall survey and certification workload for both State and CMS regional offices. Providers subject to survey and certification include not only nursing homes, but hospitals, home health agencies, dialysis facilities, hospices, intermediate care facilities for the mentally retarded, ambulatory surgical centers, and others. Figure 3 illustrates the total cumulative effect of increased numbers of all types of regulated providers. Among the provider types with the largest growth in numbers are: dialysis centers (up 19 percent from 2002 to 2007), home health agencies (up 26 percent), hospices (up 32 percent), and ambulatory surgical centers (up 39 percent from 2002 to 2007).
- **More Responsibilities:** The quality assurance responsibilities for State and Federal survey and certification continue to increase, with transplant center surveys being the most recent addition (beginning in late 2007).

In the context of such resource limitations, expanding the number of SFF nursing homes would lead to a reduction in the frequency of surveys for other provider types and would be imprudent at this time. To the extent that Congress is able to support fully the President's proposed budget for survey and certification in 2008, we would envision expansion then.



Consumer Information on CMS' Nursing Home Compare Web site

The CMS Web site (*Nursing Home Compare*) provides consumers, families, and others with key information about every nursing home. It includes information on the prevalence of pressure ulcers, the use of restraints, pain management, and other quality measures of interest to consumers. *Nursing Home Compare* also includes a summary of any quality of care deficiencies identified by surveyors in the previous three years. The Web site remains one of the most frequently-used CMS internet sites, with over 1.6 million page-views by the public each year. We continue to take steps to make publicly reported data as reliable and accurate as possible under current authority. For example, in 2006 CMS added information regarding whether a nursing home has fire safety sprinklers as well as the types of deficiencies related to fire safety.

The GAO recommended that CMS post information on the Web site regarding sanctions imposed on each nursing home. We agree that this will be useful information for consumers. Effective in 2008, CMS will begin to post information in an accessible location on the Web site regarding those nursing homes that have a history of poor quality and have had multiple sanctions imposed. For nursing homes with a history of serious and repeated harm to individuals, the history of sanctions may be a good predictor of future behavior. For example, nursing homes with eight or

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more sanctions during the 3-year period of 2001-2003 had a 100 percent chance of deficiencies that involved additional sanctions in the next year, 2004. We will establish a threshold for the publication of such sanction history based on our analysis of the predictive power of past sanctions.

A Comprehensive, Transparent Approach

The CMS published its 2007 *Nursing Home Action Plan* in September 2006. The *Plan* includes a description of some of our improvements related to enforcement. The *Plan* also summarizes our comprehensive strategy for nursing home quality and describes 39 separate initiatives in five inter-related and coordinated approaches. A copy of the *Nursing Home Action Plan* can be found at <http://www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/2007ActionPlan.pdf>. Additional actions related to enforcement effectiveness, as described in Attachment One, will be incorporated into the 2008 *Action Plan*.



Appendix VI: Comments from the Centers for Medicare & Medicaid Services

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Response to Recommendations GAO-07-241 Nursing Home Enforcement

GAO Recommendation	CMS Action
<p>A. Immediate Sanctions Policy</p> <p>Address weaknesses that undermine effectiveness of policy.</p> <p>(1) Reduce lag time between citation of double G and implementation of a sanction;</p> <p>(2) Prevent nursing homes that repeatedly harm residents or place them in immediate jeopardy from escaping sanctions; and</p> <p>(3) Hold States accountable for reporting in Federal data systems serious deficiencies identified during complaint investigations so that all complaints are considered in determining when immediate sanctions are warranted.</p>	<p>A.1 Reduce lag time for immediate sanctions. CMS will limit to no more than 30-60 days the prospective date for which a DPNA will take effect, unless the DPNA is combined with a civil monetary penalty in a structured program of progressive enforcement.</p>
	<p>A.2 Escaping Sanctions. CMS will remove the limitation in the "double G" policy on applying an additional sanction simply because a nursing home has not completed corrections to a deficiency that gave rise to a previous sanction.</p>
	<p>A.3 Obtain Additional Information on Complaints Investigated under State-Only Authority. CMS will gather more information about complaint investigations conducted under State authority and for which data is not reported in the Federal data systems.</p> <p>The Social Security Act does not provide authority for CMS to require States to report enforcement actions taken under State-only authority if Federal resources are not used for the complaint investigation.</p>
	<p>A.4 Assess Complexity of Current Immediate Sanctions (i.e., Double G Policy) and Consider Alternatives. We believe the complexity of our immediate sanction process may be impeding the full implementation of the policy by States and CMS-RO. CMS will consider either (a) improving the current policy or (b) developing an alternative policy that could be more easily understood and implemented.</p>
<p>B. Strengthen Deterrent Effect of Available Sanctions</p> <p>(1) Ensure the consistency of CMPs by issuing guidance such as the standardized CMP grid piloted during 2006.</p> <p>(2) Increase the use of discretionary DPNA's to help ensure the speedier implementation of appropriate sanctions.</p> <p>(3) Strengthen the criteria for terminating homes with a history of serious, repeated noncompliance by limiting the extension of termination dates, increasing the use of discretionary terminations and exploring alternative thresholds for termination, such as the cumulative duration of noncompliance.</p>	<p>B.1 Issue CMP (Civil Money Penalty) Analytic Tool. CMS will issue an analytic tool that includes a scope and severity framework for CMS regional offices to monitor enforcement actions, communicate with States, address outliers that significantly depart from the norm, and improve national consistency. We believe such guidance will also mitigate the extent to which civil monetary penalties tend to cluster at the lower end of the allowable range, particularly for nursing homes with repeated, serious quality of care deficiencies.</p>
	<p>B.2 Develop And Disseminate Triage Policy to Guide States in Implementing Discretionary DPNA's And Terminations. As stated in our 2007 <i>Nursing Home Action Plan</i>, CMS will issue further guidance for States on factors to be considered in determining whether a discretionary DPNA is imposed or a termination date set earlier than the time periods required by law (3-months for DPNA's, and 6-months for TPA's).</p>
	<p>B.3 Actions to Address NHs that are Seriously, Chronically, Poor-Quality Providers. CMS will work with States, consumer organizations, stakeholders, and others to design proposals for a better combination of robust enforcement actions that is effective for seriously underperforming nursing homes with repeated quality of care deficiencies, and which does not penalize vulnerable residents for the failures of nursing home management.</p>

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GAO Recommendation		CMS Action
<p>C. Increase Deterrent Effect of Civil Money Penalties</p> <p>Recommend that the Administrator develop an administrative process (or Medicare/Medicaid payments be withheld) prior to the exhaustion of appeals. Seek legislation for implementation if appropriate.</p>	C.1	<p><u>Seek Legislative Authority to Collect Civil Money Penalties During Appeal.</u> CMS will develop and seek approval for legislative change to the Social Security Act to permit the Secretary to set up an escrow account to collect CMPs while a nursing home pursues its administrative appeals process. Currently, the Social Security Act does not provide this option.</p>
<p>D. Further Expand the Special Focus Facility (SFF) Program</p> <p>Recommend that CMS include all homes that meet a threshold to qualify as poorly performing nursing home.</p>	D.1	<p><u>SFF Terminations.</u> CMS will use the SFF initiative to pilot test ideas for a more effective enforcement approach to nursing homes with serious and repeated quality of care deficiencies.</p>
	D.2	<p><u>SFF Case Studies.</u> CMS will track the trajectory of nursing facilities in the SFF initiative and develop case studies that may also be helpful in answering the question of why some nursing homes improve and others do not.</p>
	D.3	<p><u>SFF Involvement of All Responsible Parties.</u> CMS will improve the SFF policy by ensuring that all responsible parties – including the boards of directors and the owners - are fully informed at the outset regarding the seriousness of the facility's deficiencies, the seriousness of CMS enforcement actions, and the imperative for improvement.</p>
<p>E. Improve Effectiveness of Enforcement Data</p> <p>(1) Develop the enforcement-related data systems' abilities to interface with each other in order to improve the tracking of monitoring of enforcement (such as developing an automatic interface between systems such as AEM and ACTS). (2) Expedite the number of national enforcement reports, including longitudinal and trend reports designed to evaluate the effectiveness of sanctions and enforcement policies, and a concrete plan for using the reports. (3) Develop and institute a system of quality checks to ensure the accuracy and integrity of AEM data, such as periodic data audits conducted as part of CMS' annual state performance reviews.</p>	E.1	<p><u>Linkage between AEM and ACTS.</u> CMS will analyze the feasibility and cost of system modifications that would give users the ability to access AEM while in ACTS and to access ACTS while in AEM.</p>
	E.2	<p><u>National Standard Enforcement Reports.</u> CMS will continue to work with users to develop national reports that can viewed at the State, region and National levels. At least four reports will be completed in 2007. Any additional progress is dependent on funding.</p>
	E.3	<p><u>Data Accuracy Checks.</u> CMS will develop a protocol for interactive feedback between Regions and States to promote data accuracy as the Regions oversee and monitor State survey agencies. CMS will review data from its multiple data systems, including AEM on a periodic basis, to check on data accuracy.</p>
<p>F. Improve Consumer Information</p> <p>(1) Expand CMS' Nursing Home Compare Web site to include implemented sanctions (such as the amount of CMP and duration of a DPNA) and homes subjected to immediate sanctions.</p>	F.1	<p><u>Include Enforcement Information on Nursing Home Compare Web Site</u> Effective in 2008, CMS will post information in an accessible location on the website regarding those nursing homes that have a history of poor quality and have had multiple sanctions imposed. CMS will establish a threshold for the publication of such sanction history based on an analysis of the predictive power of past sanctions.</p>

Appendix VII: Comments from the California Department of Health Services



State of California—Health and Human Services Agency
Department of Health Services



ARNOLD SCHWARZENEGGE
Governor

FEB - 2 2007

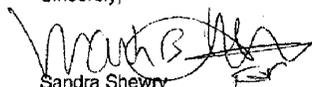
Kathryn G. Allen, Director
Health Care
Government Accountability Office
441 G Street, NW, Room 5A14
Washington, DC 20548

Dear Ms. Allen:

The California Department of Health Services (CDHS) is pleased to present its response to the Government Accountability Office's (GAO) proposed report entitled, "NURSING HOMES: Efforts to Strengthen Federal Enforcement Have Not Deterred Some Homes from Repeatedly Harming Residents (GAO-07-241)." The CDHS recognizes and appreciates the effort required to prepare this report. Please thank Mr. Walter Ochinko and Ms. Joann Jee on behalf of the CDHS.

If you have any questions, please contact Kathleen Billingsley, R.N., Deputy Director of Licensing and Certification Division, at (916) 440-7360.

Sincerely,



Sandra Shewry
Director

Enclosure

cc: See next page

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**Appendix VII: Comments from the State of
California—Health and Human Services
Agency Department of Health Services**

Kathryn G Allen
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FEB - 2 2007

cc: Kathleen Billingsley, R.N.
Deputy Director
Licensing and Certification
1615 Capitol Avenue, MS 3000
P.O. Box 997413
Sacramento, CA 95899-7413

Appendix VII: Comments from the State of
California—Health and Human Services
Agency Department of Health Services

California Department of Health Services
Response to GAO Draft Audit Report

"NURSING HOMES: Efforts to Strengthen Federal Enforcement Have Not
Deterred Some Homes from Repeatedly Harming Residents"

The California Department of Health Services (CDHS) concurs with the overall conclusions and recommendations in the draft report. CDHS concurs that the enforcement process used by the state agency in conjunction with the Centers for Medicare & Medicaid Services (CMS) Region IX was accurately depicted.

Now on p. 19.

- CDHS generally agrees with the statements on bottom of page 16 and top of 17. "Across the four states we reviewed, the proportion of homes with serious deficiencies in fiscal year 2005 ranged from 8 percent in California to 23 percent in Michigan. As we previously reported, such disparities are more likely to reflect inconsistencies in how states conduct surveys rather than actual differences in the quality of care provided by homes." CDHS notes that the definition of what constituted harm was prescribed by CMS Region IX staff. Until late 2004, evidence of permanent outcome had been required. The new definition had an impact on the number of determinations of harm in California.

Now on p. 30.

- CDHS generally agrees with the statements on page 26. Mid-page the report states, "In California, complaints typically are investigated under state licensure authority and the findings generally are not recorded in the same manner as deficiencies cited under the federal process, which may contribute to lower double G citation rates in the state. Thus, California homes are not cited for a double G when the subsequent deficiency equivalent to a G-level or higher deficiency was found during a complaint investigation." If the finding during a complaint investigation is equivalent to a G-level but is processed using the state citation system, the outcome is not recorded in the federal system. There is no mechanism to record a state citation in the federal database. If the outcome of harm is recorded in both the federal and state database, the provider would have cause to challenge, since California Health & Safety Code section 1423(a)(2) states in part, "No violation may result in the issuance of both a citation pursuant to state laws and the recommendation that a federal civil monetary penalty be imposed." All state citations have a mandatory civil monetary penalty (CMP). Even though a CMP may not be assessed on a G-level deficiency, the presence of the finding in both databases may reflect on the provider as having separate serious violations on their record.

Now on p. 31.

- CDHS generally agrees with the statements on page 27 at the top, "The California Department of Health Services conducted a pilot to test the use of the federal complaint procedure in select district offices, in part because

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"NURSING HOMES: Efforts to Strengthen Federal Enforcement Have Not
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of the low double G citation rate. As of November 2006, the Department decided not to expand or complete a formal evaluation of the pilot; instead, the Department is focusing on eliminating their backlog of complaints and initiating complaint investigations within required timeframes." All of the field offices have direction to transition into an abbreviated federal survey or use the state citation system if an outcome of harm is determined during a complaint investigation. The choice depends upon multiple variables in the situation.

Now on p. 38.

- CDHS generally agrees with the table on page 32. Table 7 describes an incident in a California home where the resident choked (and subsequently died) and no functional suction equipment was available. CDHS issued a "AA" state citation related to this event and assessed a CMP of \$60,000. The "AA" citation class is the highest in the state process and is only used if the violation is a proximate cause of the resident's death.

Now on p. 39.

- CDHS generally agrees with the footnote at the top of page 33 that states, "These data likely understate the quality problems at this home because California primarily conducts complaint investigations under its state licensure authority and did not record serious deficiencies identified during such investigations in OSCAR." CDHS cannot enter state findings (a deficiency or a state citation for an egregious violation) in OSCAR.

Now on p. 44.

- CDHS disagrees with the statement on page 37 in the first paragraph that states, "For example, California officials acknowledged that confusion by state survey agency officials as to what constituted actual harm had contributed to the decline in citations of serious deficiencies in California." California officials were not confused. CDHS received clear new direction from Region IX staff that a determination of harm must include a permanent outcome for the resident. Statements of deficiencies that included a fractured pelvis and dehydration requiring acute hospital stays were assessed at the G level by the state agency field staff but were downgraded by CMS Region IX to D level deficiencies during this time period.

Now on p. 47.

- CDHS agrees with the concerns regarding data communications in the middle section of page 40. The monitoring alert function of ASPEN (Automated Survey Processing Environment) Enforcement Manager (AEM) was not functional or available to California until January 2007, primarily due to firewall issues and system differences in the state. It was

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only then that CMS Region IX staff was immediately aware that an enforcement action with recommended remedies had been entered into the system. Significant workload to copy, e-mail, or overnight mail survey documents is finally diminished and expedited reviews and recommendations can now occur

- CDHS agrees with the recommendations for immediate payment of CMPs or withholding from payment sufficient funds to cover the CMP and placement of funds into an escrow account pending appeal

Appendix VIII: Comments from the Michigan Department of Community Health



JENNIFER M. GRANHOLM
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JANET OLSZEWSKI
DIRECTOR

February 1, 2007

Mr. Walter Ochinko, Assistant Director
United States Government Accountability Office
Washington, DC 20548

RE: GAO Draft Report: *Efforts to Strengthen Federal Enforcement Have Not Deterred Some Homes from Repeatedly Harming Residents (GAO-07-241)*

Dear Mr. Ochinko:

Janet Olszewski, Director of the Department of Community Health, has authorized me to submit comments to the Government Accountability Office's (GAO) draft report *Efforts to Strengthen Federal Enforcement Have Not Deterred Some Homes from Repeatedly Harming Residents (GAO-07-241)*.

Thank you for allowing Michigan the opportunity to discuss its enforcement system with GAO staff. We appreciate the feedback contained in the GAO report. Our belief is that Michigan has made significant progress in the implementation of its enforcement system since 1999. Michigan's enforcement has evolved from a primarily educational response to deficiencies; to minimal per instance civil money penalties; to the progressive enforcement system that exists today. We believe that Michigan's current enforcement system is a fair, consistent and thoughtful approach to addressing nursing home deficiencies that provides incentives to compliance. Under Michigan's system, poor performing nursing homes receive increasing penalties which lead to sustained compliance or termination.

We offer the following comments to issues raised by GAO:

State Agency Authority Is Limited To "Recommendations" To CMS

State Agencies are criticized for not making more effective use of enforcement remedies. The selection of remedies is not entirely under State Agency control. They may recommend, but not impose without Centers for Medicare and Medicaid Services (CMS) approval. State Agencies do not have the authority to impose civil money penalties or discretionary denial of payment, the most effective remedies, without CMS approval.

Lack Of Immediate Sanction

The 15-day waiting period for the effectiveness of discretionary denial of payment is problematic for states and well documented in the GAO report. We support immediate effect, or at least a reduction of the 15 day notice in recognition that notices are now electronically transmitted to facilities and delivery can be verified. Under the current system, a Civil Money Penalty (CMP)

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Mr. Walter Ochinko
February 1, 2007
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with immediate effect is more effective than discretionary denial of payment for new admissions (DPNA) due to the 15-day grace period and the likelihood that the DPNA will not take effect. The GAO study notes that Michigan prefers to impose CMPs. The reason is because of the certainty of the penalty and because daily penalties encourage nursing homes to expedite a return to compliance.

National Leadership On Enforcement Is Critical To Strengthening The Effectiveness of Enforcement Remedies.

As GAO notes, CMS has provided minimal guidance to State Agencies in selection and imposition of enforcement remedies. Following the 1999 GAO report, Michigan sought specific guidance from CMS and solicited enforcement process information from other states. In 2000, Michigan independently initiated the development of a CMP grid based on the general guidance contained in the CMS State Operations Manual. The initial grid was shared with CMS Region V representatives. Comments were received and adopted. This grid has evolved over time and has been used effectively to provide consistent and progressively more severe CMP sanctions, as our CMP recommendations to CMS were approved. We were pleased to see that the CMS Central Office developed a proposed CMP schedule similar to Michigan's, but were disappointed that CMS stopped short of mandating the use of their CMP grid, or approved State alternative CMP grid, in all states. That likely accounts for the disparate application of CMPs across the nation.

Michigan often recommends imposition of discretionary DPNA when a facility fails to maintain compliance for extended periods between enforcement cycles or due to findings of substantial noncompliance including harm or substandard quality of care. Unfortunately, the 15-day notice (grace period), combined with the CMS policy that evidentiary compliance is not necessary on a first revisit, often results in this remedy being rescinded by CMS before actually going into effect and its imposition has no consequence. (States are required to "assume" the compliance date is the date alleged in the Plan of Correction unless the survey team finds evidence of noncompliance. See SOM 7317B and Survey and Certification Letter 01-10.) CMS' revisit policy may account for the decrease in the duration of DPNAs noted in GAO's review of DPNA from 2000-2002 and 2003-2005.

The appropriate time to impose discretionary termination is immediately following a survey finding substantial noncompliance problems. Even the most troubled facilities can write an acceptable plan of correction and address known deficiencies following a poor survey. Provided an opportunity to fix compliance issues following a survey with knowledge that the State Agency will be returning in about two months, or at least following the date the facility asserts compliance, it is not surprising that most deficiencies are corrected on revisit. Some may even be corrected at the time the Plan of Correction is received. However, this misses the point that facilities are responsible for sustained compliance. Survey Agencies and the survey process should not substitute for nursing home quality assurance process. The current practice of moving to terminate a facility after one or more compliance verification revisits with decreasing citations in an enforcement cycle is counterintuitive. At that point in the process, termination for a few remaining citations appears to be a disproportionately harsh remedy when an opportunity to correct many deficiencies has already been provided.

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In December 2006, Michigan developed a tool to evaluate discretionary termination for facilities with poor compliance histories. Again, as GAO points out, there is no CMS national guidance on this subject. In early 2007, a nursing home in Michigan meeting the criteria for discretionary termination received the State Agency's "recommendation" for termination with no request for a Plan of Correction. The CMS Region V Office mandated that we send out a revised notice requesting a Plan of Correction and, as of this writing, has failed to send out its official notice of enforcement. Meanwhile, the facility is under the assumption it will be allowed to correct its deficiencies.

Without CMS guidance on the important aspects of enforcement, and subsequent methods to ensure that all states follow this guidance, the issues identified in the GAO report will not be resolved nationally. However, some states are active on enforcement. Michigan prides itself in this regard. But, nonetheless, a consistent national approach is needed.

Michigan recommends termination dates of less than six months for all Special Focus Facilities and in situations where a facility has recently completed an enforcement cycle and fails to maintain compliance. CMS Region V has been supportive of these recommendations and the reduced time frames provide a clear incentive for the early correction of deficiencies.

Need For Comprehensive Survey Data Base

We suggest that as part of a nationwide standard to change enforcement practices to deter nursing homes from repeated harm citations, CMS mandate that State Agencies file all survey data, including state authority investigations, with CMS. The complete history of the facility must be used to assess the nursing home's overall performance and determine remedies that must be imposed. It is unfair to hold some states accountable for CMS performance standards, when other states are allowed to withhold information from the program for performance review.

Michigan's Enforcement System Goes Beyond CMS Requirements

Under Michigan's enforcement system, facilities that continue to harm residents or provide substandard quality of care receive more severe enforcement recommendations commensurate with their compliance history, repeat citations, and the scope and severity of the citations in the current survey. In addition to the "Double G" determination that mandates remedies, a survey event that has two or more harm level or above citations will result in a CMP recommendation. If a facility has had a CMP imposed during the preceding 24 months or two standard survey cycles, the recommended CMP will always be at least as high as the previously imposed CMP. The progressive nature of this enforcement approach works to remove poor performers. Some of Michigan's "voluntary" terminations were situations where the facility had received survey results that warranted severe remedy imposition. The owners made business decisions to voluntarily terminate.

Factors Considered When Deciding To Recommend Termination

GAO notes that states frequently give "lack of availability of beds in an area" as a reason for not recommending termination. The decision of whether to recommend termination is more complex than checking alternate nursing home sites. Many factors are considered. The first, of

Mr. Walter Ochinko
February 1, 2007
Page Four

course, is the trauma that residents might suffer in any relocation and the risk inherent to transferring any resident, including those with special needs. The State considers the proximity of available beds in the area so that families can remain in contact with residents. Also considered are the special care needs of residents. Some residents, for example those with behavior issues, are difficult to place. Relocation can be challenging. This is true especially in rural areas. While it is true the enforcement history transfers with a change of ownership, progress by a current owner may be a reason to not recommend discretionary termination even if a harm citation is issued.

In states that have Certificate of Need standards or licensing requirements that rely on certification, termination of Medicare/Medicaid status can result in closure and the loss of a community resource for nursing care.

Examples of Homes With Low Implemented CMPs

GAO includes an example of a situation in which a resident was harmed by a medication error to support its contention that CMS did not take advantage of the full range of sanctions for the homes reviewed. In this case, the State Agency recommended, and CMS approved, a per instance civil money penalty of \$1500 for a situation involving a medication error that occurred over a three day period resulting in hospitalization of the resident. The allowable range for per instance CMPs is \$1000 to \$10,000.

This event occurred in August 2001. As has been stated previously, during that time Michigan had a preference for per instance civil money penalties while it was developing a CMP policy that later was finalized. Our experiences from 2000 and 2001 convinced us that a \$1500 civil money penalty is not an effective deterrent to non-compliance. Had the current CMP grid been in effect in 2001, the penalty would have been \$300 per day for 102 days, a total of \$29,400. We believe that to be more appropriate to similar situations.

A Michigan Home Reviewed Cycled In and Out of Compliance Nine Times for Fiscal Years 2000 through 2005

Michigan agrees that the nursing home that is the subject of this comment deserved special attention because of its compliance problems on standard surveys and abbreviated (complaint) surveys. But the analysis of its compliance issues is more complex than counting enforcement cycles. Five of the nine cycles for a five year period are not unusual with one standard survey in each 12 months. In addition, this facility was designated a "Special Focus Facility" in January 2005 which requires surveys every 6 months so an additional survey would be expected. This leaves three "exceptional" or additional surveys over a 5 year period. We determined this facility should have special focus because of compliance problems. GAO is correct this facility is still open. It has shown progress in resolving its compliance issues and will likely be removed from the Special Focus Facilities list. This example and the next example illustrate the conflict faced by State Survey Agencies in the absence of specific termination criteria; judging whether a poor performing facility is capable of systemic change and should be given an opportunity to correct deficiencies, or whether it should be terminated without any opportunity to correct.

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February 1, 2007
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Example of Nursing Home Deficiency History and Termination Action 2000-2005

GAO presents an example of a Michigan home that had 95 D-level or higher deficiencies and cycled out of compliance seven times. Again, five enforcement cycles for a nursing home in five years is not unusual due to the practice of conducting standard surveys at 12 month intervals. Arguably two additional cycles over a five year period is not excessive. However, the number of citations exceeds state survey averages. State Agency staff worked with this facility to reduce citations, with some progress. It is a candidate for special review at next survey to determine if it should be terminated without further opportunity to correct because of poor surveys in 2006.

We believe that an effective enforcement system is an important component to improving nursing care. We appreciate GAO's review and recommendations. Please contact me if you require clarification of any part of this response.

Sincerely,

Mike Dankert

Mike Dankert, Director
Bureau of Health Systems

cc: Janet Olszewski
Jan Christensen
David McLaury

Appendix IX: Comments from the Texas Department of Aging and Disability Services



COMMISSIONER
Adelaide Horn

February 2, 2007

Kathryn G. Allen
Director, Health Care
United States Government Accountability Office
Washington, DC 20548

Re: *NURSING HOMES: Efforts to Strengthen Federal Enforcement Have Not Deterred Some Homes from Repeatedly Harming Residents* (GAO-07-241)

Dear Ms. Allen:

Thank you for the opportunity to review and to make comments prior to the publication of this report.

We have reviewed your recommendations to the Centers for Medicare and Medicaid Services (CMS) and look forward to playing our role in implementing any strategies that CMS puts in place. As you mention in the report, CMS has developed a standard CMP (civil money penalty) grid that the states may use in determining CMP amounts. We have been using this grid since June 2006 and have found it to be very helpful.

You also note that CMS has revised the Special Focus Facility Program, although you note that the program is limited to a relatively small number of facilities. Although we were only required to include five facilities in our Special Focus Facility activities, Texas elected to include six facilities.

In addition, the CMS Dallas Regional Office supports our use of discretionary denial of payment for new admissions.

Regarding the specific details of the report, in the last sentence of the first paragraph on page 18, directly before Table 4, you accurately state that the Texas state survey agency does not recommend more than one type of money penalty for the same deficiency. However, this statement was not accurate for the entire time period covered by this study (i.e., federal fiscal years 2000-2005). Prior to September 1, 2003, the Texas state survey agency was authorized to recommend both a state money penalty as well as a federal CMP. After that date, by virtue of a change in state law, we were only authorized to assess *either* a state money penalty *or* a CMP. This change may have had an impact on the amount of CMPs imposed after September 1, 2003.

701 W. 51st St. ★ P.O. Box 149030 ★ Austin, Texas 78714-9030 ★ (512) 438-3011 ★ www.dads.state.tx.us

Now on p. 20.

Appendix IX: Comments from the Texas
Department of Aging and Disability Services

Ms. Kathryn G. Allen
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Page 2

Now footnote 41 on p. 21.

The wording of footnote 40 on page 19 may not be easily understood by persons unfamiliar with the licensure practice of our state. I would recommend the following wording for footnote 40:

“This home is located in Texas, where the state issues a license to the person or entity that operates the nursing home rather than to the owner of the real property. The majority of nursing homes in Texas are operated out of leased property. When the home was recertified, the new operator was licensed; there was no change in the owner of the real property.”

Now on p. 51.

On page 43, in the last full sentence of the last paragraph, the statement regarding the use of state rather than federal sanctions for G-level or higher deficiencies only addresses part of the issue. As stated earlier, it is true that after September 1, 2003, the state is only authorized to assess *either* a state money penalty *or* a CMP. What this statement does not capture is that, while the maximum amount of per day CMP that may be assessed is \$10,000, the maximum amount of state penalty that may be assessed is \$20,000 per violation, per day. Thus, for example, if a nursing facility is found to have violated three separate state rules for one day and the finder of fact determines that the violations warrant the maximum amount of penalty, the total amount of penalty assessed would be \$60,000. If those same violations were found to have taken place over two days the amount assessed could be \$120,000, and so on. I would recommend adding the following language to the end of that sentence to read as follows: “Texas state officials often use state rather than federal sanctions for G-level or higher deficiencies, in part because they cannot propose a federal CMP if they impose a state sanction, and because the total state penalty amount that may be imposed may be greater than the amount of CMPs that may be imposed.

Please let me know if you have any questions or need additional information. Veronda L. Durden, Assistant Commissioner for Regulatory Services, is serving as the lead staff on this matter and can be reached at (512)438-2625 or by e-mail at veronda.durden@dads.state.tx.us.

Sincerely,



Adelaide Horn
Commissioner

AH:vld

Appendix X: GAO Contact and Staff Acknowledgments

GAO Contact

Kathryn G. Allen, (202) 512-7118 or allenk@gao.gov

Acknowledgments

In addition to the contact names above, Walter Ochinko, Assistant Director; Elizabeth Bradley; Jacquelyn Clinton; Joanne Jee; Elizabeth T. Morrison; Colbie Porter; Jessica Smith; and Karin Wallestad made key contributions to this report

Related GAO Products

Nursing Homes: Despite Increased Oversight, Challenges Remain in Ensuring High-Quality Care and Resident Safety. [GAO-06-117](#). Washington, D.C.: December 28, 2005.

Nursing Home Deaths: Arkansas Coroner Referrals Confirm Weaknesses in State and Federal Oversight of Quality of Care. [GAO-05-78](#). Washington, D.C.: November 12, 2004.

Nursing Home Fire Safety: Recent Fires Highlight Weaknesses in Federal Standards and Oversight. [GAO-04-660](#). Washington D.C.: July 16, 2004.

Nursing Home Quality: Prevalence of Serious Problems, While Declining, Reinforces Importance of Enhanced Oversight. [GAO-03-561](#). Washington, D.C.: July 15, 2003.

Nursing Homes: Public Reporting of Quality Indicators Has Merit, but National Implementation Is Premature. [GAO-03-187](#). Washington, D.C.: October 31, 2002.

Nursing Homes: Quality of Care More Related to Staffing than Spending. [GAO-02-431R](#). Washington, D.C.: June 13, 2002.

Nursing Homes: More Can Be Done to Protect Residents from Abuse. [GAO-02-312](#). Washington, D.C.: March 1, 2002.

Nursing Homes: Federal Efforts to Monitor Resident Assessment Data Should Complement State Activities. [GAO-02-279](#). Washington, D.C.: February 15, 2002.

Nursing Homes: Sustained Efforts Are Essential to Realize Potential of the Quality Initiatives. [GAO/HEHS-00-197](#). Washington, D.C.: September 28, 2000.

Nursing Home Care: Enhanced HCFA Oversight of State Programs Would Better Ensure Quality. [GAO/HEHS-00-6](#). Washington, D.C.: November 4, 1999.

Nursing Home Oversight: Industry Examples Do Not Demonstrate That Regulatory Actions Were Unreasonable. [GAO/HEHS-99-154R](#). Washington, D.C.: August 13, 1999.

Related GAO Products

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

Nursing Homes: Complaint Investigation Processes Often Inadequate to Protect Residents. [GAO/HEHS-99-80](#). Washington, D.C.: March 22, 1999.

Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards. [GAO/HEHS-99-46](#). Washington, D.C.: March 18, 1999.

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

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