

Government Monitoring & Oversight of Nursing Home Care: The Relationship Between Federal and State Agencies

With

Recommendations for Improving Oversight of State Performance

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Acknowledgements

The authors are grateful to Toby Edelman, Senior Policy Attorney at the Center for Medicare Advocacy, for agreeing to read a final draft of this report. Her comments and suggestions were very helpful.

Thanks also goes to CMS Region 2 staff and the Northeast consortium staff for their willingness to give us information and to share their thoughts with us.

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Government Monitoring & Oversight of Nursing Home Care: The Relationship Between Federal and State Agencies

EXECUTIVE SUMMARY

The purpose of this study is to gain insights into the relationship between the Centers for Medicare & Medicaid Services (CMS) and state survey agencies, specifically with respect to how these agencies ensure that all participating nursing homes meet or exceed minimum federal standards. CMS is responsible for monitoring the care of all beneficiaries of Medicaid and Medicare no matter where they access care. For those in nursing homes, it contracts out this responsibility to the states. It then has the role of monitoring state performance.

Monitoring State Performance. In order to ensure that state surveyors are conducting inspections adequately, CMS monitors state surveying procedures and functioning through the Federal Monitoring Program. This Program consists of a number of different monitoring activities:

Federal Oversight/Support Surveys (FOSS). In a Federal Oversight/Support Survey (FOSS), CMS surveyors accompany state surveyors on inspections or complaint investigations and assess the state surveyors' performance in identifying issues and determining deficiencies.

Comparative Surveys. CMS also conducts "comparative" surveys at nursing homes that have previously been inspected by state inspectors. The findings of the federal surveyors are compared to the findings made by state surveyors a month or less earlier.

Annual State Performance Standards System Evaluation. CMS evaluates state performance annually, using the State Performance Standards System Guidance. This system measures the frequency with which surveys are conducted; the quality of the surveys; and the appropriateness and effectiveness of enforcement.

Performance Measures – "Threshold Criteria." In order to measure the performance of state agencies in meeting their responsibilities, CMS analyzes a compilation of various surveys, including those conducted by state agencies, as well as observational (FOSS) and

comparative surveys conducted by CMS itself. If a state does not meet the minimum threshold level, CMS must impose a remedy or sanction against the state.

Definition of Inadequate State Performance. CMS is required to consider survey performance to be inadequate if the state survey agency demonstrates a "pattern of failure" in a number of areas such as identifying deficiencies; utilizing enforcement actions to assure continued compliance; responding to complaints in accordance with requirements; or failing to identify any "immediate jeopardy" situation.

Sanctions/Remedies Against States. If a state demonstrates inadequate performance, as defined above, CMS is required to take corrective measures. It can choose between a number of different measures. The first category listed below of "remedies/alternative sanctions" is "intended to assist states in improving their survey and certification program performance." The second category of "sanctions" is generally meant to be "employed after remedies/alternative sanctions have been tried and a state has not been successful in adequately performing its survey functions."

Remedies/Alternative Sanctions: Under this first category, CMS may (1) provide for training of survey teams; (2) direct a Quality Improvement Plan; (3) provide technical assistance on scheduling and procedural policies; (4) require the state to undertake improvements specified in a plan of correction; or (5) provide CMS directed scheduling.

Sanctions: Under this more harsh category, CMS may (1) place state on compliance for failure to follow the Medicaid State Plan; (2) meet with the governor and other responsible state officials; (3) reduce federal financial participation for survey and certification of nursing facilities, or (4) initiate action to terminate the agreement between the Secretary and the State, either in whole or in part.

The State Operations Manual states that, when deciding which remedy or sanction to impose, CMS is required to "consider circumstances beyond the degree of culpability of a state's ability to perform due to circumstances beyond the control of the state governor." It is worth noting, however, that this requirement is not in the law, or the regulations implementing the law, itself.

Determining Failure to Cite Deficiencies. In order to evaluate the state's work, CMS follows a specific protocol to determine whether a state agency has demonstrated a "pattern of failure" to identify deficiencies. If the disparity rate between federal and state findings on comparative surveys is greater than 20 percent the state has a "pattern of failure." However, before this determination, the state is given an opportunity to explain why there is a discrepancy. If the disparity rate continues to be greater than 20 percent, CMS will advise the state that unless it can rebut the findings, or can offer compelling

reasons for CMS to excuse the high disparity, a determination of pattern of failure to identify deficiencies will be made and the federal financial participation made to the state will be reduced.

How Well is the CMS-State Relationship Working Across the Nation? Several reports over the past decade have brought to light a number of serious flaws in the CMS-State relationship. Although CMS seems to have a number of different remedies and sanctions at its disposal and detailed steps relating to appropriately determining when there has been a "pattern of failure," there has been a persistence of understatement of serious care problems by state agencies and weaknesses on the part of CMS in its ability to monitor and correct these state deficiencies. A specific case will demonstrate why this may be so and how things may be improved.

A Specific Case: The Relationship Between New York State and CMS

CMS Region 2 Lacks Resources. CMS's central office is in Baltimore and there are a number of Regional Offices throughout the country monitoring state performance. New York State is in CMS Region 2. Region 2 staff is responsible for overseeing all facilities that receive Medicaid and Medicare funding. This includes monitoring care given by eleven different types of providers in addition to long term care residences in New York and three other states and territories. Despite these numerous and wide-ranging responsibilities, and studies by the Government Accountability Office and others that poor care is a persistent problem in nursing homes, CMS has experienced a significant depletion of its workforce.

New York State Performance and CMS Region 2's Oversight Activities. Although there are some indications that the New York DOH might be improving in terms of identifying immediate jeopardy situations and enforcing regulations, there is still a wide gap between New York DOH survey findings and Region 2 comparative survey findings. There are a high frequency of instances in which the state does not identify deficiencies found by the federal surveyors or does not categorize deficiencies it does find correctly (as to their scope and severity). In addition, as of the publication of this report, only 13 percent of all on-site inspections of complaints lead to deficiencies against the nursing home. While these findings should mean that New York is demonstrating a "pattern of failure" to identify deficiencies, sanctions have not been imposed from the second (more serious) category of sanctions. Region 2 staff have stated that it is impossible to evaluate New York State without conducting comparative and FOSS surveys throughout the state and this has not been possible, given their resources. Of all the remedies and sanctions available to Region 2, training and technical assistance are the only two remedies utilized in relation to New York State.

This limited scope of action seems to indicate that Region 2 has decided to function more as an educator than a regulator. While, on the one hand, this may appear inadequate (when persistent nursing home problems are inadequately identified and addressed by the state), on the other hand more significant sanctions (such as the reduction of federal funding or termination of the relationship entirely) pose their own unique sets of problems. A reduction in federal funding would likely only exacerbate issues with DOH's performance, since the state agency has been consistently underfunded. The option to terminate the contract with the state would mean that CMS would have to find another agency or organization to undertake the duties outlined in the contract. This may be difficult, if not impossible to do. In addition, even if such an organization was found, transition would undoubtedly entail tremendous additional costs.

Recommendations

- 1. Modify the language relating to sanction and remedies in the State Operations Manual to better reflect the law and its purpose.**
- 2. Modify the State Operations Manual to remove or significantly curtail states' ability to dispute citations for poor performance, except in extraordinary circumstances.**
- 3. In order to improve CMS regional offices' ability to evaluate whether a state is performing adequately, CMS should require that its regional offices include past state performance in various homes in its selection of nursing homes for their FOSS and comparative surveys.**
- 4. Provide sufficient funding for CMS oversight and state oversight.**
- 5. The criteria for determining a "pattern of failure" in state performance must be modified or refined so there is never a situation in which a pattern of failure cannot be found because CMS officials have determined that they are not conducting sufficient surveys to make such a finding.**
- 6. Change the State Performance Standards System Guidance to focus on quality inspections.**

NOTE: Please see the Recommendations section of the full report for a full description of the recommendations.

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INTRODUCTION

The federal Centers for Medicare & Medicaid Services (CMS) is responsible for ensuring that all healthcare providers that participate in the Medicare and/or Medicaid programs

It is the duty and responsibility of the Secretary to assure that requirements which govern the provision of care in nursing facilities... and the enforcement of such requirements, are adequate to protect the health, safety, welfare, and rights of residents and to promote the effective and efficient use of public moneys.

- Social Security Act, §1919 (f)(1)

are in compliance with federal health and safety standards. To ensure that nursing homes that participate in one or both of these programs (the vast majority of U.S. nursing homes) meet these standards, CMS delegates responsibility to state governments, which oversee quality assurance in the nursing homes within their states. This delegation is carried out through a written contract with each state, usually a state's department of health (DOH), to conduct surveys (inspections) of individual nursing homes¹ as well as to provide other quality assurance functions, such as responding to consumer complaints about a facility's care. Because these contractual activities are the principle means by which providers are held accountable for meeting

federal standards, they are critical to ensuring both quality of care for nursing home residents across the country as well as appropriate use of the government funding that pays for a substantial portion of nursing home care. Thus, the efficacy of CMS's oversight of each state agency's performance in its surveying and oversight activities, as dictated by these contracts², is crucial.

¹ Under these contracts, states are required to conduct surveys of facilities participating in the Medicare and Medicaid programs at least once every fifteen (15) months, with the statewide average interval for these surveys not to exceed twelve (12) months, and conduct complaint investigations. State personnel usually simultaneously assess compliance with federal certification and state licensure requirements for the participating facilities in the state.

² Specifically, it is the CMS Survey and Inspection Group that oversees the surveying process. In addition to federal regulations, states also promulgate state "licensing" requirements, which generally follow federal "certification"

The purpose of this study is to gain insights into the relationship between CMS and state survey agencies, specifically with respect to how these agencies together carry out their missions to ensure that all participating nursing homes meet or exceed minimum standards. What is the nature of their contractual relationship? What are the rights and obligations of each party to the contract? What can CMS do to encourage (or compel) a state agency to do a better job when nursing home residents are not provided with care and quality of life that meet or exceed minimum standards? How do these rights and obligations “play out” in the real world: how does CMS determine whether a state is doing a good job? What actions *can* CMS take to improve the performance of state oversight when there are problems? What actions *does* CMS take in such situations? To gain insights into these specific questions we focused on our home state, New York, and the workings of the relationship between NYDOH and CMS.

Our goal in conducting this study – and issuing this report - was not to cast blame on either the state or federal agencies but, rather, to identify ways in which the quality of this contractual relationship can be improved. It is well known and widely acknowledged that serious problems with nursing home care and quality of life persist, despite the passage over two decades ago of the federal Nursing Home Reform Law,³ which set forth the rights of every nursing home resident in the country to (among other things) sufficient care and services to attain and maintain his or her highest practicable physical, mental, and psychosocial well-being. Why is there such a disconnect between these established federal standards and the reality of nursing home life for so many residents and their caregivers and loved ones? Why do many nursing homes continue to fail (at times tragically) so many of our frail elderly and disabled? Given that the typical nursing home resident lives in a home for approximately two years, there have now been over ten generations of residents since the Reform Law standards were enacted. How many of them suffered because their nursing homes were not held accountable for providing inadequate care or a poor quality of life? How many are destined to suffer in the future if providers are not held accountable for providing good care?

“Why is there such a disconnect between established minimum federal standards and the reality of nursing home life...?”

This report begins by describing the basis and nature of the relationship between CMS and the states, and their joint responsibility to ensure that nursing homes meet federal

standards. Facilities are *licensed* to operate according to state regulations and then *certified* to CMS by the state as being in compliance with federal standards.

³ In 1987, Congress passed the Nursing Home Reform Law as part of the Omnibus Reconciliation Act, 1987.

standards. It is important to recognize that the CMS-state agency relationship is unique. While both parties are regulatory agencies, CMS maintains a supervisory role over the state. CMS is empowered not only to aid the state agencies, but also to impose sanctions against them in instances of non-compliance. An effective relationship between the two entities is key to ensuring provider accountability.

Contracts

The contracts between CMS and individual state agencies are agreements to carry out Section 1864 and other related provisions of the Social Security Act, which outline the specific obligations of CMS and nursing facilities under federal law. The methods of reimbursement to state agencies for conducting standard, follow-up, and complaint investigation surveys are outlined by the 1864 Agreement between CMS and the state agency. These agreements stipulate that payment is based on the “reasonable cost” of performing surveying functions, including the training and payment of surveyors, as well as the planning and coordination activities that the survey and certification process involves.⁴

Monitoring State Performance

CMS has ten Regional Offices (ROs) across the country that oversee and facilitate the implementation of CMS policy on the local level. Each RO is responsible for monitoring the performance of a number of states. In order to ensure that state surveyors are conducting inspections adequately and complying with the 1864 agreement, CMS monitors state surveying procedures and functioning through the Federal Monitoring Program. The Federal Monitoring Program includes two types of federal surveys as well as state program integrity reviews. The State Operations Manual outlines the standards and measures for state performance, as well as the sanctions and remedies that can be taken against states for non-compliance.⁵ These provisions are further elaborated on in the CMS State Performance Standards System Guidance document, which lays out a Frequency-Quality-Enforcement & Remedy rubric for measuring state survey performance.⁶ States are evaluated annually using this system.

⁴ See § 1864(b) of the Social Security Act, 1935.

⁵ See Centers for Medicare & Medicaid Services, *State Operations Manual, Chapter 8 – Standards and Certification*, May, 2004 (<https://www.cms.gov/manuals/downloads/som107c08.pdf>).

⁶ See CMS, FY 2010 State Performance Standards System Guidance.

Federal Oversight/Support Surveys (FOSS)

One type of federal monitoring survey is the Federal Oversight/Support Survey (FOSS), formerly “observational surveys,” during which federal CMS surveyors accompany state surveyors on inspections or complaint investigations and assess the state surveyors’ performance in identifying issues and determining deficiencies.⁷ The federal surveyors then review their results with the state surveyors and provide guidance and feedback to state surveyors to improve their inspection techniques.⁸

Comparative Surveys

CMS also conducts “comparative” surveys at nursing homes that have previously been inspected by state inspectors. The law requires CMS to conduct “a sufficient number” of comparative surveys “to allow inferences about the adequacies of each state’s surveys” that were conducted as part of the state’s contractual agreement with CMS.⁹ To satisfy the “sufficient number” requirement, federal surveyors must conduct comparative surveys of at least five percent of the number of skilled nursing facilities surveyed by the state in that year.¹⁰ Comparative surveys may be conducted on a sample basis or in response to complaints made by a resident, a resident’s family member, or some other interested party. Federal inspectors must conduct comparative surveys within one month of the state-run survey¹¹ and compare CMS findings with those of the state in order to evaluate the quality of state inspections and to identify the training needs of state agency employees. In general, federal surveyors conduct onsite surveys of a representative sample of nursing homes¹² in each state. For purposes of uniformity, federal and state surveyors utilize the same survey protocols.¹³ Results of both the FOSS and comparative surveys are recorded in the Federal Monitoring Survey database.

Integrity Reviews

In addition to conducting observational and comparative surveys, CMS’s Central Office also conducts state program integrity reviews every three years, as well as on an as-needed basis. During these reviews, CMS must assess the effectiveness of state programs in preventing and detecting fraud and abuse of Medicare and Medicaid services by nursing

⁷ Minnesota Department of Health, *Appendix D: Actions to Promote Integrity Through Consistent Implementation of the Survey Process*, 2003.

⁸ Interview with Region 2 staff, January, 2010.

⁹ See § 1819(3)(A) of the Social Security Act, 1935.

¹⁰ See § 1819(3)(B) of the Social Security Act, 1935.

¹¹ Prior to 2002, CMS was required to conduct comparative surveys within two months of the state survey.

¹² Skilled Nursing Facilities (SNFs) are facilities that are eligible to participate in, and be reimbursed by, Medicare. Nursing Facilities (NFs) are facilities which are eligible to participate in, and be reimbursed by, Medicaid.

¹³ *State Operations Manual, 8000D(15)*; “Scope” refers to the number of residents affected or threatened by a deficiency; whereas “severity” refers to the seriousness of the deficiency. See Appendix I for the CMS Scope-Severity table..

facilities. CMS also must examine state processes for enrolling long term care facilities in CMS programs, and determine whether facilities enrolled in the programs are providing the proper disclosure forms to residents.¹⁴

Overall Reliability Determination

CMS also examines the overall reliability of the state-run administration of CMS programs.¹⁵ CMS focuses on the state's scheduling and surveying procedures and practices, as well as the state's use of managed care principles to maximize efficiency and effectiveness in administering the Medicare and Medicaid programs. In terms of scheduling and surveying practices, CMS must make sure that surveys are unannounced, as required under federal law, and that state practices do not give advance notice of surveys to facilities.¹⁶ CMS also must determine whether the state has met the twelve-month statewide average interval requirement for conducting surveys.¹⁷ Finally, CMS must observe the state agency's relationship with the state's Medicaid Fraud Control Unit (MFCU) to ensure that the state agency is efficiently identifying instances of Medicaid fraud.¹⁸ While conducting program integrity reviews, CMS is also required to take note of individual state practices that are particularly effective and then compile a Program Integrity Review Annual Summary report, disseminating information to each state on how best to administer CMS programs.¹⁹

Annual State Performance Standards System

Each region evaluates state performance annually (usually in two parts; some measures are conducted semi-annually to make sure evaluation of them is timely), using the State Performance Standards System Guidance. This system measures the frequency with which surveys are conducted; "the quality of the surveys; and the appropriateness and effectiveness of enforcement."²⁰ CMS has taken steps to improve this guidance over the years. For example, in early 2010, a performance measure was implemented that assesses whether states are identifying deficiencies accurately.²¹

¹⁴ U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, *State Program Integrity Reviews*, October, 2009, available at

http://www.cms.hhs.gov/FraudAbuseforProfs/05_StateProgramIntegrityReviews.asp.

¹⁵ *Id.*

¹⁶ See Code of Federal Regulations: Title 42: Public Health § 488.307.

¹⁷ See Code of Federal Regulations: Title 42: Public Health § 488.308.

¹⁸ U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, *State Program Integrity Reviews*, October, 2009, available at

http://www.cms.hhs.gov/FraudAbuseforProfs/05_StateProgramIntegrityReviews.asp.

¹⁹ *Id.*

²⁰ Centers for Medicare & Medicaid Services, *FY2010 State Performance Standards System Guidance*.

²¹ As noted later, despite these efforts, the focus is still on process rather than quality of inspection.

State Performance Standards

The Social Security Act Section 1864 Agreement (§ 1864 Agreement) incorporates, but is not limited to, a list of twenty-one key performance standards and measures that state agencies must meet in order to comply with CMS contracts. By entering into an 1864 Agreement with CMS, the state expressly promises to uphold these key performance standards; failure to do so is breach of contract. One example of a performance standard is the requirement that the state ensure: “Organization and staffing of the state survey agency to enable fulfillment of the functions under the agreement.”²² Another standard requires that “[s]cope and severity decisions for nursing home deficiencies are accurate and supportable.”²³ For a full listing of all the standards, please see Appendix III.

Performance Measures – “Threshold Criteria”

In order to measure the performance of state agencies in meeting their responsibilities under the terms of the 1864 Agreements, CMS analyzes a compilation of various surveys, including those conducted by state agencies, as well as comparative and observational (FOSS) surveys. CMS is required to measure state performance against the standards according to a minimum level of competence criteria.²⁴

Definition of Inadequate State Performance

Generally, the Regional Office (RO) will consider state agency performance to be inadequate when analysis of survey data indicates a systemic problem in some aspect of state performance.²⁵ CMS considers survey performance to be inadequate if the state survey agency:

²² Centers for Medicare & Medicaid Services, *State Operations Manual, 8000D(1)* and more specifically *8000(D)(13)* “Ongoing surveyor training programs develop and maintain surveyor proficiency.” Chapter 8 of the State Operations Manual lays out the State Performance Standards. It outlines the definition of inadequate survey performance, lists the performance standards as required in the § 1864 Agreement, and explains CMS’s evaluation process to determine if performance standards have been met. It also sets out the sanctions available and the State’s rights, both formal and informal, when CMS has imposed sanctions. This document is illustrative of the allocation of rights and responsibilities between the federal and state agencies.

<https://www.cms.gov/manuals/downloads/som107c08.pdf>.

²³ *State Operations Manual, 8000D(15)*; “Scope” refers to the number of residents affected or threatened by a deficiency; whereas “severity” refers to the seriousness of the deficiency. Please see Appendix I for the CMS Scope-Severity table.

²⁴ See *State Operations Manual, § 8000F – Performance Criteria*. May, 2004.

²⁵ See *Id. at § 8000H – Imposing Sanctions Other Than Federal Financial Participation*.

1. Demonstrates a pattern of failure to: ²⁶

- Identify deficiencies, and the failure cannot be explained by changed conditions in the facility or other case specific factors;
- Cite only valid deficiencies;
- Conduct surveys in accordance with the requirements of the manual;
- Use federal standards, protocols, and the forms, methods, procedures, policies and systems specified by CMS in instructions;
- Utilize enforcement actions to assure continued compliance;
- Input online data timely and accurately;
- Conduct surveys in accordance with required timeframes;
- Respond to complaints in accordance with requirements;
- Lead in the implementation by providers of federally required patient assessment instruments or data sets; and/or
- Operate federally required systems for the collection of patient assessment data.

Or

2. Fails to identify an “immediate jeopardy” situation.

Sanctions/Remedies Against States

If a state demonstrates inadequate performance, as defined above, CMS is required to take corrective measures. However, ROs are given much flexibility in their choice of remedy or sanction and, although not in the law or the regulations, according to the state manual, when deciding which remedy or sanction to impose, CMS “will consider the degree of culpability of a State’s ability to perform due to circumstances beyond the control of the state governor.”²⁷ The State Operations Manual lists both “remedies/alternative sanctions” as well as “sanctions” that CMS can utilize in order to improve state performance.²⁸ There is a loose hierarchical distinction between the two categories of corrective actions. The first category of “remedies/alternative sanctions” is “intended to assist States in improving their survey and certification program performance.”²⁹ The second category of “sanctions” is generally meant to be “employed after

²⁶ See *Id.* at §8000C – Definition of Inadequate State Survey Performance.

²⁷ See *Id.* at §8000G – Available Sanctions/Remedies.

²⁸ See *Id.* at §8000G – Available Sanctions/Remedies and Title 42: Public Health Section 488.320: Sanctions for inadequate survey performance.

²⁹ See *Id.* at §8000B – Purpose.

remedies/alternative sanctions have been tried and a state has not been successful in adequately performing its survey functions.”³⁰ According to the State Operations Manual, “[t]he purpose of remedies/alternative sanctions and sanctions is to work with States having difficulty in correcting problems, resorting to reduction in funding and contract responsibilities only as a last resort.”³¹ The choices include:

Category 1: Remedies/Alternative Sanctions:

- Providing for training of survey teams;
- Directing a Quality Improvement Plan;
- Providing technical assistance on scheduling and procedural policies;
- Requiring the State to undertake improvements specified in a plan of correction; and
- Providing CMS directed scheduling.

Category 2: Sanctions:

- Placing state on compliance for failure to follow the Medicaid State Plan;
- Meeting with the governor and other responsible state officials;
- Reducing federal financial participation for survey and certification of nursing facilities,³²
- Initiating action to terminate the agreement between the Secretary and the State under §1864 of the Act, either in whole or in part.³³

Determining Failure to Cite Deficiencies and Imposing Sanctions

One of the most important responsibilities of state agencies under the §1864 agreements is accurately identifying deficiencies in long-term care facilities. Reduction of financial participation can only be done in cases where the Regional Office has determined that the

³⁰ See *Id.* at §8000B – Purpose.

³¹ See *Id.* at §8000B – Purpose.

³² “Federal financial participation will only be reduced when the state demonstrates a pattern of failure to identify or accurately classify deficiencies in nursing facilities. The Act does not allow for imposition of this sanction when the failure to identify or accurately classify deficiencies occurs in Medicare-only facilities when the nature of the inadequacy is anything other than a failure to identify deficiencies.” Centers for Medicaid & Medicare Services, *State Operations Manual*, §§ 8000 F – Performance Criteria; 8000G – Available Sanctions/Remedies; 8000I – Reducing Federal Financial Participation for Pattern of Failure to Identify Deficiencies in Nursing Facilities, May, 2004. In addition to “pattern of failure” situations, funding can also be proportionately reduced if a state does not conduct all tasks required by the contract, e.g., does not inspect all nursing homes within a 15 month time frame.

³³ *Id.* at § 8000G – Available Sanctions/Remedies.

state has demonstrated a "pattern of failure" to identify deficiencies. In order to evaluate the state's work in this regard, CMS follows a specific protocol. Once the state has

“...a reduction in federal funding is rarely utilized, even when the language of the Manual and the law indicate that such action is required.”

conducted a survey of a facility pursuant to CMS regulations, and CMS has conducted its own comparative survey, CMS calculates the disparity between the number of deficiencies cited on each survey. CMS then averages all of the percentages calculated for each facility in the state at the end of each quarter of the fiscal year. If the quarterly disparity rate is less than 20 percent, CMS may impose sanctions on the state (other than a reduction of funding), but is not obligated to do so. If the disparity rate is over 20 percent reduction of financial participation is to be considered. However, before imposing a reduction in federal funding, the State Manual requires the RO to confer with the state on the root causes of the disparities, to give the state an opportunity to correct and to dispute CMS findings. The state will have the remainder of the quarter in which the root causes were identified as well as the succeeding

quarter to correct. Federal surveys performed in the quarter following the correction period are evaluated to determine whether the state has been successful.

If the disparity rate is again greater than 20 percent after the four quarters, the Regional Office must give the state another chance to rebut the findings used to calculate the disparity rate or offer compelling reasons for the Regional Office to excuse the high disparity. If it cannot do so, the Regional Office will consider there to be a pattern of failure to identify deficiencies in nursing facilities, and will reduce the federal financial participation made to the state.³⁴

It should be noted that the rules require that a finding of non compliance will stand if there is a disagreement between CMS and the state.³⁵ For instance, if the “State survey agency finds that a facility is not in substantial compliance, but the regional office finds, either through an onsite survey or review of the State survey agency’s findings, that the facility is in substantial compliance, the State survey agency’s finding prevails.”³⁶ On the other hand, “[i]f the State survey agency finds a facility is in substantial compliance, but the regional office finds, either through an onsite survey or review of the State survey agency’s findings,

³⁴ See Centers for Medicare & Medicaid Services, *State Operations Manual § 8000I – Reducing Federal Financial Participation for a Pattern of Failure to Identify Deficiencies in Nursing Facilities*, May, 2004.

³⁵ See *State Operations Manual*, 7807B - *Disagreement About Whether Facility Has Met Requirements*. (Rev. 1, 05-21-04).

³⁶ *Id.*

that the facility is not in substantial compliance, the regional office's finding prevails."³⁷ Thus, regardless of whether the state or the RO determines a facility is not in substantial compliance triumphs, that finding holds when there are conflicting findings.³⁸

In October 2007, CMS established a formal dispute resolution process for comparative surveys for states to dispute CMS findings. Such a process had already been in place for the FOSS surveys.³⁹

These policies and procedures present significant hurdles to the imposition by CMS of a reduction in federal financial participation when a state has been found to have problems identifying nursing home deficiencies, even when the state's problems are persistent. In addition to the multiple levels of procedural hurdles, in practice (as will be noted later) the decision to cite a pattern of failure seems to take more into account than just the 20 percent threshold. Thus, a reduction in federal funding is rarely utilized, even when the language of the Manual⁴⁰ and the law⁴¹ indicate that such action is required.

CMS Monitoring of State Enforcement Actions in Immediate Jeopardy Cases

CMS evaluates state survey agency performance in all cases where an "immediate jeopardy" (IJ) situation is discovered. An "immediate jeopardy" situation is defined in the regulations as a situation in which "the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident."⁴²

CMS is required by law to take immediate jeopardy situations very seriously; "even a single failure to identify an immediate jeopardy situation *will* be considered inadequate State survey performance."⁴³ [Emphasis added.] In the event of an IJ, the Regional Office is required to select one or more sanctions appropriate to the inadequacy. However, the reduction of federal financial participation is *not* permitted as a response to a state's failure to identify IJ situations.⁴⁴ Reduction of federal financial participation is *only* available

³⁷ *Id.*

³⁸ See also, *State Operations Manual, 7807C - Disagreement About Decision to Terminate* (Rev. 1, 05-21-04).

³⁹ See U.S. Government Accountability Office, *Nursing Homes: Federal Monitoring Surveys Demonstrate Continued Understatement of Serious Care Problems and CMS Oversight Weaknesses*, page 20.

⁴⁰ See *Id.* at §8000G – Available Sanctions/Remedies.

⁴¹ Code of Federal Regulations: Title 42: Public Health § 488.320, "Sanctions for inadequate survey performance."

⁴² 42 C.F.R. §488.301. See also CMS State Operations Manual, Appendix Q – "Guidelines for Determining Immediate Jeopardy." (Note: do you want to give the URL?)

⁴³ See *State Operations Manual, § 8000H – Imposing Sanctions Other Than Federal Financial Participation Reduction.*

⁴⁴ *Id.*

where there is a pattern of failure to identify deficiencies in nursing facilities⁴⁵ which, as will be discussed below, is almost impossible to determine.

In the event of an IJ, the state must notify the Regional Office no later than two calendar days after the last day of the survey in which the immediate jeopardy was identified. The state must also notify the office of whether or not the IJ had been removed.⁴⁶ The notification of whether or not IJ has been removed from a nursing home must be no less than three working days prior to the possible termination date.⁴⁷ [Please refer to Appendix VI of this report for the CMS evaluation formula.]

How Well is the CMS-State Relationship Working Across the Nation?

Several reports over the past decade have brought to light a number of serious flaws in the CMS-State relationship. Since 1998, the U.S. Government Accountability Office (GAO) has reported numerous times on nursing home quality-of-care issues and identified significant weaknesses in federal and state oversight.⁴⁸ Federal monitoring surveys have indicated the persistence of understatement of serious care problems by state agencies and weaknesses on the part of CMS in its ability to monitor and correct these state deficiencies.⁴⁹

In 2009, GAO released two reports criticizing CMS's current approach for funding state oversight of health care facilities⁵⁰ and addressing the widespread understatement of serious care problems by states.⁵¹ Their findings indicate that functional weaknesses both jeopardize the safety and well-being of nursing home residents and undermine the efficient use of taxpayer dollars. Clearly these are problems of great importance; moreover, their persistence points to the need for broad-based measures for improvement.

⁴⁵ *Id.*

⁴⁶ *Id.*

⁴⁷ *Id.*

⁴⁸ See, U.S. Government Accountability Office, *Nursing Homes: Prevalence of Serious Quality Problems Remains Unacceptably High, Despite Some Decline*, GAO-03-1016T, July 17, 2003; See also, U.S. Government Accountability Office, *Nursing Home Quality: Prevalence of Serious Problems, While Declining, Reinforces Importance of Enhanced Oversight*. GAO-03-561. July 15, 2003.

⁴⁹ See U.S. Government Accountability Office, *Nursing Homes: Federal Monitoring Surveys Demonstrate Continued Understatement of Serious Care Problems and CMS Oversight Weaknesses*. GAO-08-517. May 9, 2008; See also, *Nursing Home Quality: Prevalence of Serious Problems, While Declining, Reinforces Importance of Enhanced Oversight*. GAO-03-561. July 15, 2003.

⁵⁰ U.S. Government Accountability Office, *Medicare and Medicaid Participating Facilities: CMS Needs to Reexamine Its Approach for Funding State Oversight of Health Care Facilities*. GAO-09-64. February 13, 2009.

⁵¹ See U.S. Government Accountability Office, *Nursing Homes: Addressing the Factors Underlying Understatement of Serious Care Problems Requires Sustained CMS and State Commitment*. GAO-10-70. November, 24 2009.

The failure on the part of states to fulfill their contractual obligations with CMS is perhaps best evidenced by CMS’s comparative and observational survey findings. This mechanism, as discussed above, allows the federal government to double-check the state’s work to ensure that the state is appropriately identifying deficiencies. This is of utmost importance because by the very nature of the relationship, CMS relies on states to appropriately identify harm and take corrective action against offending facilities.

“...it is evident that state survey agency performance limits the federal government’s ability to obtain an accurate picture of how often nursing home residents face actual harm or are at risk of serious injury or death.”

- U.S. Government Accountability Office

Unfortunately, the data indicate that some states have not done well. The GAO found that during fiscal years 2002 through 2007, “about 15 percent of federal comparative surveys nationwide identified state surveys that failed to cite at least one deficiency at the most serious levels of noncompliance—actual harm and immediate jeopardy.”⁵² Overall, nine states missed serious deficiencies on 25 percent or more of

comparative surveys. During the same period, missed deficiencies at the level of “the potential for more than minimal harm” were more widespread: nationwide, approximately 70 percent of federal comparative surveys identified state surveys missing at least one deficiency at this level of noncompliance, and in all but five states the number of state surveys with such missed deficiencies was greater than 40 percent.

These statistics cannot be taken lightly. GAO stated in alarming terms, “[w]ith about one in six comparative surveys concluding that state survey teams had missed a serious deficiency or understated its scope and severity level, it is evident that state survey agency performance limits the federal government’s ability to obtain an accurate picture of how often nursing home residents face actual harm or are at risk of serious injury or death.”⁵³ In fact, these missed serious deficiencies most frequently reflected “shortcomings in *fundamental provider responsibilities* such as ensuring proper nutrition and hydration, accident prevention, and preventing pressure sores.”⁵⁴ [Emphasis added.]

In short, the absence of a well-functioning CMS-State relationship, wherein both parties fulfill their contractual obligations to enforce minimum nursing home standards, puts

⁵² U.S. Government Accountability Office, *Nursing Homes: Federal Monitoring Surveys Demonstrate Continued Understatement of Serious Care Problems and CMS Oversight Weaknesses*. GAO-08-517, (cover page). May 9, 2008.

⁵³ *Id.* at 27.

⁵⁴ *Id.*

nursing home residents at risk of abuse and neglect. In addition to the tremendous personal costs to the health, safety, and dignity of frail elderly and disabled residents, weaknesses in the functioning of the oversight system result in tremendous financial costs and waste, in terms of both the public monies paid year after year to nursing home providers that fail to achieve minimum standards and the costs associated with “cleaning up” the results of inadequate nursing home care (for instance, the unnecessary hospitalization of neglected nursing home residents).

A SPECIFIC CASE: HOW WELL IS THE RELATIONSHIP BETWEEN NEW YORK STATE & CMS WORKING?

CMS Region 2

New York State is in CMS Region 2, along with New Jersey, Puerto Rico, and the Virgin Islands.⁵⁵ CMS is responsible for overseeing all facilities that receive Medicaid and Medicare funding. As a result, it is responsible for monitoring care by eleven different types of providers in addition to long term care residences. For monitoring purposes, Region 2 conducts a total of 63 surveys each year.⁵⁶ Additionally, Region 2 serves as the state agency in the US Virgin Islands, with direct responsibility for conducting inspections of facilities and complaint investigations. [Please see Appendix III for a complete list of facilities overseen by Region 2.]

Despite these numerous and wide-ranging responsibilities (and their critical importance for protecting residents), CMS has experienced a significant depletion of its workforce. The number of federal surveyors in Region 2 has decreased from fifteen to eight in recent years. These eight surveyors are responsible for completing all of the aforementioned sixty-three monitoring surveys. They are co-supervised by two managers, a survey manager and a manager of certification and enforcement.⁵⁷

⁵⁵ Regions are also organized in a Consortia structure based on the Agency's key lines of business: Medicare health plans, Medicare financial management, Medicare fee-for-service operations, Medicaid, and children's health, survey & certification and quality improvement. The intent of this structure is to improve performance through uniform issue management, consistent communication and leadership focused on achieving the Agency's strategic action plan. See <http://www.cms.hhs.gov/regionaloffices/>.

⁵⁶55 surveys of long term care facilities and 8 surveys of other provider types.

⁵⁷Telephone interview with Region 2 supervisors, March 9, 2010.

New York State Performance

The Government Accountability Office (GAO) findings cited above for the country are indicative of the problems in New York: there is a wide gap between New York DOH survey findings and CMS comparative survey findings. In 2005, LTCCC conducted a study of New York State's survey system and found that for the years 2002 to 2004, CMS inspectors identified over four times the number of violations than did NYDOH for the same facilities. Similarly, information obtained by LTCCC under the Freedom of Information Act (FOIA), detailing comparative surveys for the years January 2008 to July 2009, indicates that CMS comparative surveys uncovered deficiencies at well over three times the New York DOH rate (see Appendix IV for details of the comparative surveys in New York State). In addition, only 13 percent of all on-site inspections of nursing home complaints led to the nursing home being cited for a deficiency.⁵⁸

GAO has reported similar findings. In 2008, GAO found 22.2 percent of total comparative surveys in NY identified at least one missed deficiency at the "Actual Harm" or "Immediate Jeopardy" levels. Furthermore, GAO found that 55.6 percent of total comparative surveys uncovered at least one deficiency missed by the NYDOH with "Potential for More Than Minimal Harm."⁵⁹ Finally, two recent reports by GAO indicate that New York is, in fact, a leader in understatement of deficiencies among states with large senior populations.⁶⁰

There are some indications that the New York DOH might be improving. Studies that examine the "Percentage of Facilities Receiving a Deficiency for Actual Harm or Immediate Jeopardy" in New York show a general upward trend in recent years, from 15.67 percent in 2003 to over 24 percent in the years 2006 and 2007 (although in 2008 it dropped to 19.69 percent).⁶¹ A continuing upward trend could be indicative of a positive trend of the effectiveness of the state's oversight. In addition, in 2009, enforcement actions in the state increased slightly: the number of state and federal fines increased from 101 to 103 and the amounts imposed rising from \$1,072,443 to \$1,413,183.⁶² CMS's annual rating of New York

⁵⁸ Data as collected from DOH website, www.health.state.ny.us, May 10, 2010.

⁵⁹ U.S. Government Accountability Office, *Nursing Homes: Federal Monitoring Surveys Demonstrate Continued Understatement of Serious Care Problems and CMS Oversight Weaknesses*. GAO-08-517. May 9, 2008 (page 34, Appendix II). Available at: <http://www.gao.gov/new.items/d08517.pdf>.

⁶⁰ GAO reports examined the percentage of federal comparative surveys that noted serious deficiencies missed by state surveyors in five major states (CA, FL, NY, OH, and TX) during the five year period from March 2002 – March 2007). The reports found that New York led the group with a high of 26 percent understatement. See GAO, *Despite Increased Oversight, Challenges Remain in Ensuring High-Quality Care and Resident Safety*, GAO-06-117 (Washington, D.C.: Dec. 28, 2005); and *Nursing Home Reform: Continued Attention Is Needed to Improve Quality of Care in Small but Significant Share of Homes*, GAO-07-794T (Washington, D.C.: May 2, 2007).

⁶¹ Charlene Harrington, *Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2003 Through 2008*, Table 34, p.81. Available at <http://nccnhr.org/sites/default/files/OSCAR%20complete%202009.pdf>.

⁶² Long Term Care Community Coalition, *Annual Report Card on Government Protection in LTC in 2009*, p. 2. Available at: http://www.ltccc.org/publications/documents/reportcard2009web_000.pdf.

State's oversight, as determined by the State Performance Standards System Guidance, would provide further insight into CMS's evaluation of New York State's performance. Unfortunately, LTCCC's request for this information under FOIA (the Freedom of Information Act) was denied.⁶³

CMS Region 2's Oversight Activities

Difficulty in Determining a "Pattern of Failure"

Although, as mentioned above, there are some indications that the New York DOH might be improving in terms of identifying immediate jeopardy situations and enforcing regulations, there is still a wide gap between New York DOH survey findings and Region 2 comparative survey findings. Too often, the state does not find deficiencies that are subsequently identified by federal surveyors. Of the deficiencies that the state does find, there is a persistent problem with categorizing them correctly as to their scope and severity. While this should mean that New York is demonstrating a "pattern of failure" to identify deficiencies, sanctions have not been imposed from the second, more serious, category of sanctions available to CMS.⁶⁴ Region 2 staff have stated that it is difficult, if not impossible to determine that New York State has a pattern of failure. A pattern of failure, as Region 2 staff defined it, means broad, systematic failure, across the entire state.⁶⁵ According to Region 2 staff, the Regional Office typically tries to conduct between one and two comparative surveys per month in New York State. In order to select nursing homes for comparative surveys, Region 2 takes several criteria into consideration, including geographic location, size, roster of state survey team (they try not to go out with the same team), and the availability of federal surveyors.

"Under current operations and interpretation of the law, the levying of more serious sanctions is unlikely ever to occur whether or not there is actually a pattern of failure to identify problems in New York nursing homes."

Unfortunately, certain contingencies sometimes interfere with Region 2's selection of facilities. For instance, it is not uncommon for Region 2 to be unable to conduct surveys at certain facilities as a result of personnel shortages and logistical limitations. Thus, in a given month, Region 2 may be forced to limit its selection to a smaller facility or one closer

⁶³ As of this writing, LTCCC is continuing efforts to procure this information. If it is obtained, this report will be updated accordingly and re-posted on our nursing home information website: www.nursinghome411.org.

⁶⁴ See, *supra* pp. 14-15.

⁶⁵ Meeting with Region 2 and the Northeast Consortium supervisors, January 21, 2010 and telephone interview with Region 2 supervisors on March 9, 2010.

to its office in Manhattan, rather than one that an appropriate application of its criteria would suggest.⁶⁶ Limited geographical federal surveys in fact are conducted. Eight out of the nine comparative surveys conducted by Region 2 in New York State in 2008 and part of 2009, that we obtained under FOIA, were of facilities located in the greater New York City metropolitan area.⁶⁷ Given the size of the state and the severe personnel limitations of the Region 2 office, a determination that a “pattern of failure” exists across the entire state is unlikely to ever occur, because the office cannot conduct a sufficient number of surveys, over a sufficiently wide geographical area, for such a determination to be possible under its self-imposed criteria. Thus, under current operations and interpretation of the law, the levying of more serious sanctions is unlikely ever to occur whether or not there is actually a pattern of failure to identify problems in New York nursing homes.

Too Few Different Types of Sanctions Are Imposed

In fact, of all the remedies and sanctions available to Region 2 to ensure that the state is fulfilling its responsibilities⁶⁸ (and to ensure, in turn, that nursing homes in the state are meeting minimum standards), training and technical assistance are the only two remedies used by Region 2. While training or technical assistance might be appropriate in some cases, their predominance as the sole forms of corrective action in Region 2 has come at the expense of alternative, and possibly more effective, strategies. Region 2 has largely foregone the use of the other sanctions at its disposal, such as forming directed quality improvement plans, meeting with high-level state officials such as the governor or legislators, reducing federal financial participation, or termination of the contract between CMS and the state. The limited scope of action seems to indicate that Region 2 has decided to function only as an educator and not as a regulator. Given the ongoing issues with the state’s ability to identify deficiencies and correctly label them in terms of their scope and severity, relying only on training and technical assistance as remedies for poor state performance over the long term has not been very successful.

“Training and technical assistance are the only two remedies used by Region 2 when it finds poor state performance.”

State Operations Manual Gives Too Much Flexibility

CMS’s State Operations Manual appears to give significantly more leeway to the agency and its Regional Offices to determine which remedies or sanctions to impose than the law or the

⁶⁶ *Ibid.*

⁶⁷ Roscoe Nursing Home in Roscoe, NY was the exception.

⁶⁸ See discussion on page 7 of this report for an overview of the range of remedies and sanctions available under the law.

regulations⁶⁹ appear to have intended. For instance, the Manual requires CMS to consider circumstances beyond the control of the state governor in assessing the degree of culpability of a state, though this requirement is not called for in the language of either the law or the regulations.

Using More Significant Sanctions May Pose Problems

While limiting sanctions to training and technical assistance is clearly insufficient, more significant sanctions, on the other hand (such as the reduction of federal funding to the state or termination of the §1864 agreement entirely), pose their own unique set of problems.

States are Underfunded

Since state agencies have, historically, been underfunded, a reduction in federal funding would likely only exacerbate issues with their performance. According to the GAO, although federal funding for state surveys increased from fiscal years 2000 through 2002, it was nearly flat from fiscal years 2002 through 2007.⁷⁰ In inflation-adjusted terms, funding fell 9 percent from fiscal years 2002 through 2007. Although New York State spends about \$20 million a year on health care surveillance, it receives only about \$13 million from the federal government.⁷¹ The additional funds needed to close this gap come from the state budget (or do not; as we have seen over time, there is a political battle every year to add (or even maintain) levels of financial support). Unsurprisingly, the number of state surveyors has been dropping (see Appendix V for statistics on DOH staffing).⁷² Thus, reducing federal funds is unlikely to improve DOH results if financial restraints are already a major factor in DOH performance issues.

Changing partners would be expensive if available

The option to terminate the contract with the state would mean that CMS would have to find another agency or organization to undertake the duties outlined in the contract. This may be difficult, if not impossible, to do. In addition, even if such an organization was found, it would undoubtedly entail tremendous transitional costs.

⁶⁹ Code of Federal Regulations: Title 42: Public Health § 488.320, “Sanctions for inadequate survey performance.”

⁷⁰ U.S. Government Accountability Office, *Medicare and Medicaid Participating Facilities: CMS Needs to Reexamine Its Approach for Funding State Oversight of Health Care Facilities*. GAO-09-64. February 13, 2009.

⁷¹ Letter from NYS Director of the Budget to Region 2.

⁷² The number of state surveyors has been dropping over the last few years; in some areas it has diminished by over 15 percent.

RECOMMENDATIONS

1. Modify the language relating to sanction and remedies in the State Operations Manual to better reflect the law and its purpose.

The “Available Sanctions/Remedies” section of the State Operations Manual should be revised to clearly set forth sanctions and remedies and their use in a way that will compel compliance with the language and purpose of the state agency/CMS contract.

As it is now written, the State Operations Manual seems to limit the ability of CMS to effectively hold states accountable. In particular, while setting out clear standards and performance guidelines, the Manual at the same time undermines CMS’s potential effectiveness by stating that the agency must consider circumstances beyond the control of the state governor in assessing the degree of culpability of a state.⁷³ By providing such an open-ended opportunity for excuse, the Manual in effect makes it possible for states to avoid meaningful sanctions no matter how poor their performance in the enforcement of nursing home standards.⁷⁴ Language that permits states to be excused because of circumstances beyond their control should be eliminated entirely or, if that is not possible, refined so that this excuse can only be utilized in extraordinary and time-limited circumstances.

“Just meeting with the governor and legislative leaders and letting them know directly that the state is in danger of losing some federal reimbursement might encourage them to make sure that DOH has the necessary financial resources.”

In cases where there is a breach of contract, the Manual should set forth specific remedies and sanctions to be utilized that reflect the level of the problem with a state’s performance. For instance, when a state continues to have problems after training or technical assistance have been tried, CMS should escalate the level of sanction or remedy. Options could include: implementing a timeline for a state to come into compliance; imposing a structured plan for the state with clear benchmarks leading to compliance; and/or meeting with the state’s political leaders, such as the governor, to inform them of the gravity of the situation and the more serious sanctions that may be imposed if the state does not come into compliance with its contractual mandate.

⁷³ See Centers for Medicare & Medicaid Services, *State Operations Manual § 8000 G – Available Sanctions/Remedies*.

⁷⁴ 42 C.F.R. §488.320, “Sanctions for inadequate survey performance,” does not provide for such flexibility.

In the case of New York, these remedies might be effective in helping DOH improve in terms of identifying deficiencies. Just meeting with the governor and legislative leaders and letting them know directly that the state is in danger of losing some federal reimbursement might encourage them to make sure that DOH has the financial resources it needs to appropriately monitor the care that nursing home residents receive.

2. Modify the State Operations Manual to remove or significantly curtail states' ability to dispute citations for poor performance, except in extraordinary circumstances.

As noted earlier, when the most serious problem - failure to identify and cite deficiencies appropriately - is found, the State Operations Manual provides a number of opportunities for states to evade responsibility. For example, the Manual requires CMS to permit the state to offer evidence to rebut the charge or present compelling evidence as to why it has not accurately cited deficiencies. The state is also given the opportunity to correct such deficiencies before more severe sanctions are imposed. Even if the problems are found again, the state is given another opportunity to rebut the findings or offer compelling reasons for the Regional Office to forgo the otherwise-warranted imposition of sanctions. While the desire to consider state limitations is understandable, the result, in effect, has been that a state can exploit CMS reluctance to impose sanctions. A state's own lack of compliance is tolerated, even when that noncompliance reflects a failure to hold nursing facilities accountable for resident abuse or neglect. The result, in short, is that standards are rendered less meaningful. We would not excuse a nursing home for giving poor care if the argument is that it lacks funds or staff. Why are we permitting states to use similar arguments?

3. In order to improve CMS regional offices' ability to evaluate whether a state is performing adequately, CMS should require that its regional offices include past state performance in various homes in its selection of nursing homes for their FOSS and comparative surveys.

When selecting nursing homes for comparative and FOSS surveys, CMS should look at quality indicators in relation to state survey findings. Select homes for inclusion where the state survey findings do not seem to match the quality indicators. Select homes where state surveyors have not identified any deficiencies, few deficiencies or where most identified deficiencies are at a low severity and/or scope level. Another criteria might be to select homes with a high number of complaints by families and/or residents with little citation from state surveyors either on complaint investigation or survey. Facilities with low numbers of staff but high ratings on past state surveys should also be given priority.

4. Provide sufficient funding for CMS oversight and state oversight.

A critical issue is the chronic underfunding of both federal and state oversight of nursing home care. It is crucial that adequate funding be allocated to both the Regional Offices and the state agencies. As we saw in the case of New York, both Region 2 and DOH have been charged with a Herculean task of regulating a great number of providers with limited resources. Congress and state legislatures must understand that spending money on oversight will save money for both Medicare and Medicaid: it can reduce incidences of poor care (and its associated costs), cut down on provider fraud and increase the amount of fines collected. Most importantly, from the perspective of consumers and the public, appropriate oversight can lead to better care outcomes for nursing home residents.

“...increased spending on oversight is cost-effective... and it will undoubtedly improve care and quality of life for nursing home residents....”

A consistent theme in conversations with CMS and DOH is that state survey teams' lack of consistency is primarily caused by the state's inability to retain or backfill qualified surveyors. Perhaps CMS should require a specific number of surveyors per resident in the state, so that it is clear to states the amount of resources they are expected to contribute in order to remain in compliance. Likewise, the substantial decrease in survey staff we identified in Region 2, coupled with the significant limitations in the office's ability to conduct surveys in New York State (to the extent that its leaders believe it is unable to conduct sufficient surveys to determine if a pattern of failure exists, as required by law) indicates that there is a critical need to ensure that there are sufficient numbers of federal surveyors. As stated above, increased spending on oversight is cost-effective, as it is likely to result in significant overall savings for the Medicare and Medicaid programs, and it will undoubtedly improve care and quality of life for nursing home residents which is, of course, the fundamental purpose of the system.

5. The criteria for determining a “pattern of failure” in state performance must be modified or refined so there is never a situation in which a pattern of failure cannot be found because CMS officials have determined that they are not conducting sufficient surveys to make such a finding.

The Social Security Act explicitly states that CMS must conduct a sufficient number of surveys "to allow inferences about the adequacies of each State's surveys..." and, therefore, determine whether a state agency is in compliance. This approach by the Regional Offices is

necessary in order to ensure that meaningful oversight of a state's nursing homes is taking place, since the ability to make such a determination is a crucial component of CMS's oversight authority. Thus, Regional Offices must be required to conduct sufficient numbers and diversity of surveys to achieve this mandate. Regional Offices must either allocate sufficient resources to conduct the surveys necessary to meet its criteria of "sufficient number" or adjust this self-defined criterion of "sufficient number" to fit within the resources available for this task. It is simply unacceptable - and clearly deleterious to the safety of nursing home residents - if, as is currently the case with Region 2 and New York State, Regional Offices conduct insufficient numbers of surveys to ever allow inferences about the quality of a state's enforcement. In the specific case of Region 2, if the office is not fully funded, then it must be required to modify its self-defined criterion about how to determine a pattern of failure so that it fits within the resources available for this task.

6. Change the State Performance Standards System Guidance⁷⁵ to focus on quality inspections.

The annual review conducted by CMS focuses more on process than on the quality of a state's surveillance and investigations and the outcomes of these efforts. Despite CMS efforts to improve the annual review, the guidance system still focuses heavily on process rather than on the quality of state oversight. For example, the measurement of the appropriateness and effectiveness of enforcement action includes timeliness of processing immediate jeopardy cases: did the state notify CMS promptly, did the state conduct a timely revisit and did the state notify CMS of whether or not IJ (immediate jeopardy) had been removed. There seems to be little or no attempt to measure whether appropriate sanctions were proposed/placed by the state.⁷⁶ This dissonance is particularly stark in the case of enforcement in nursing homes in the Special Focus Facility Program. This program is a CMS initiative in which facilities that have been identified as among the very worst in the country, with significant long-term problems, are selected for intense oversight and enforcement measures. The goal of the program is to provide special oversight of these facilities so that they are helped to either implement long term solutions to their problems and "graduate" from the program or are terminated from the Medicaid/Medicare programs. Clearly, the quality of oversight in these cases is critically important. Yet, at this time, states are evaluated primarily on whether they have conducted the required number of surveys, rather than whether they are actually moving these facilities to make substantive and lasting improvements.⁷⁷

⁷⁵ See FY2010 State Performance Standards System Guidance.

⁷⁶ See *Id.* at pages 35-43.

⁷⁷ See *id.*

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In the specific case of Region 2 and New York, we found that this policy understandably results in the NYDOH focusing more on the frequency of inspections and notification requirements, and less on effectively identifying and addressing nursing home care and quality of life problems. While process is important and measurable, it cannot be focused on at the expense of fundamental purpose of government oversight: to ensure that nursing home residents receive the quality of life and quality of care that they are entitled to under the law and regulation.

APPENDIX MATERIALS

Appendix I: Scope and Severity of Deficiencies Identified during Nursing Home Surveys

Deficiencies identified during nursing home surveys are categorized according to their scope (i.e., the number of residents potentially or actually affected) and severity (i.e., the degree of relative harm involved). Homes with deficiencies at the A through C levels are considered to be in substantial compliance, while those with deficiencies at the D through L levels are considered out of compliance.

Severity	Scope		
	Isolated	Pattern	Widespread
Immediate Jeopardy*	J	K	L
Actual Harm	G	H	I
Potential for more than minimal harm	D	E	F
Potential for minimal harm**	A	B	C

* “Immediate Jeopardy” – provider’s non-compliance . . . has caused, or is likely to cause, serious injurious injury, harm impairment or death to a resident.” II 42 C.F.R. §488.301.

** If only “Potential for minimal harm” then CMS considers nursing home to be in “substantial compliance.”

“Substantial compliance” means a level of compliance with the participation requirements “such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm.”

Source: <http://www.gao.gov/new.items/d08517.pdf> (page 3, table 1)

Appendix II: State Performance Standards and Measures: State Operations Manual⁷⁸

Below is list of key performance standards and measures that state agencies must meet in order to comply with CMS contracts:

1. Organization and staffing of the State survey agency to enable fulfillment of the functions required under the §1864 Agreement;
2. Surveys are planned, scheduled, conducted, and processed timely;
3. Survey findings are supportable;
4. Certifications are fully documented, and consistent with applicable law, regulations, and general instructions;
5. Current written internal operating procedures and policies are consistent with program requirements;
6. A plan of correction is requested from a provider/supplier;
7. When certifying noncompliance, adverse action procedures set forth in regulations and general instructions are adhered to;
8. Supervisory reviews and evaluations of surveyor performance are made routinely;
9. Required financial and budget reports are submitted on time and completed in accordance with general instructions;
10. All expenditures and changes to the program are substantiated to the Secretary's satisfaction;
11. Actual survey and certification activities are consistent with the annual activity plan and workload estimate approved by CMS;
12. The performance of agencies utilized to perform specific functions under this Agreement are monitored;
13. Ongoing surveyor training programs develop and maintain surveyor proficiency;
14. Results of complaint investigations against providers and suppliers are considered in making certification decisions;
15. Scope and severity decisions for nursing home deficiencies are accurate and supportable;
16. Updates, training, and technical assistance about patient assessment instruments/data sets are supplied to providers as appropriate;
17. Federally supplied hardware and software for the system to collect patient assessments/data sets are operated in accordance with instructions;
18. The conduct and reporting of complaint investigations is timely and accurate;
19. Survey teams include surveyors with required qualifications and/or certifications;
20. Accurate and timely data is entered into online survey and certification data systems; and
21. Information on certification findings is provided to the public as required in instructions.

⁷⁸ See *State Operations Manual*, 8000D - Performance Standards Include, But Are Not Limited to the Following (Rev. 1, 05-21-04).

Appendix III: Responsibilities of CMS Region 2 Office – Number of Facilities Monitored by Type of Facility

	New Jersey	New York	Puerto Rico	US Virgin Islands	TOTAL
Hospitals	101	239	59	2	401
Nursing Homes	359	632	7	1	999
HHA	51	195	48	2	296
Xray	10	26	26	0	62
OPT	59	17	2	0	78
ESRD	121	236	37	3	397
CORF	11	6	3	0	20
ASC	222	92	27	0	341
Hospice	57	49	36	3	145
CMHC	28	4	13	0	45
FQHC	78	162	6	2	248
RHC	0	8	0	0	8
TOTAL	1097	1666	264	13	3040

Appendix IV: Results of Comparative Surveys: January 2008 – July 20, 2009⁷⁹

Home and Dates of Survey	# of Deficiencies found by DOH	# of Deficiencies Found by CMS	# DOH found at “G”⁸⁰ or Above	# CMS “G” or Above	# DOH Immediate Jeopardy	# CMS Immediate Jeopardy
Amsterdam DOH - 8/08 CMS - 9/08	1	9	0	0	0	0
Brooklyn- Queens DOH – 7/08	3	8	0	0	0	0

⁷⁹ These are all the comparative surveys sent to LTCCC under FOIA for January 2008 through July 20, 2009. LTCCC asked for the results of all the comparative surveys during that time frame.

⁸⁰ A “G” level and above deficiency means that at least harm has occurred.

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CMS – 8/08						
Home and Dates of Survey	# of Deficiencies found by DOH	# of Deficiencies Found by CMS	# DOH found at “G” ⁸¹ or Above	# CMS “G” or Above	# DOH Immediate Jeopardy	# CMS Immediate Jeopardy
Roscoe DOH - 5/08 CMS – 6/08	1	4	0	1	0	0
Hollis Park DOH – 4/08 CMS – 5/08	2	16	0	0	0	0
Willoughby DOH - 5/08 CMS – 7/08	3	31	0	9	0	6
Greater Harlem DOH - 1/08 CMS – 3/08	8	18	0	1	0	0
Resort DOH - 12/08 CMS – 1/09	4	4	1	1	0	0
Forest hills DOH - 5/09 CMS – 6/09	5	13	1	No scope/severity rating given	0	No scope/severity rating given
Robert Mapplethorpe DOH - 7/09 CMS – 8/09	3	4	0	No scope/severity rating given	0	No scope/severity rating given
Totals	30	107	2	12	0	6

It is possible that in some of these cases, given the time between surveys, circumstances may have changed; this might explain some of the findings. However, given the large differences, it cannot explain all of the variance. Importantly, in addition, there are several

⁸¹ A “G” level and above deficiency means that at least harm has occurred.

instances where DOH rated the very same issues, less severely than CMS. For example, at the Brooklyn-Queens home, the DOH rated sanitary conditions as a “D,” meaning an isolated problem, at its July, 2008 survey. CMS on the other hand gave this an “F” rating, meaning the problems were widespread, at its August 2008 comparative survey only a little over a month later.

Appendix V: Full Time Equivalents in New York DOH Nursing Home Survey Program

Date	State Employee			Contract Staff			Total Staff
	Clerical	Surveyor	Supervisor	Clerical	Surveyor	Supervisor	
Total 8/1/2007	24.1	148.4	21.95	0	29	2	225.45
Total 8/1/2008	23.55	137.4	18.35	5	30	2	216.3
Total 8/1/2009	20.81	137.22	20.35	5	30	2	215.38

As the table demonstrates, the numbers of state surveyors is going down. DOH is unable to fill positions when surveyors leave or retire. In addition, there is a threat that the legislature will remove funding for contract staff.

Data Source: FOIL Request from New York DOH.

DOH Retention Issues

Because the DOH employs RNs as surveyors, it faces significant recruitment and retention issues that result from the rigors of the surveyor position and private market competition. RNs can make significantly more money in the private setting as practicing RNs, than as state employees. While it has been debated whether DOH needs all RNs for survey teams; it is certain that the DOH at least needs some RNs for the conducting of clinical reviews.

Appendix VI: Calculation of Immediate Jeopardy

CMS calculates IJs through the following formula.

Calculation:

Identify all IJ cases that were not removed onsite.

Determine in how many of these cases, the SA notified CMS of the IJ in a timely manner, conducted a timely revisit upon receipt of a credible allegation of compliance, and notified CMS whether or not the IJ was removed within the prescribed timeframes. Determine the total number of acceptable cases.

Divide #2 and #1 and convert to a percentage format.⁸²

Scoring:

If the resulting percentage is greater than or equal to 95%, this measure is scored as “Met.”

If the resulting percentage is less than 95%, this measure is scored as “Not Met.”⁸³

For each measure that is scored as “Not Met,” the SA will develop and implement a corrective action plan that will address the identified problems. The RO will review and follow-up to ensure that the SA is progressing toward making corrections. A correction action plan is not required for developmental measures.⁸⁴
