

Mr. Chairman and Members of the Committee:

I am pleased to be here today to discuss the Health Care Financing Administration's (HCFA) progress in implementing its recent initiatives to strengthen efforts to ensure the quality of care provided by the nation's nursing homes. The nearly 1.6 million Americans who rely on the nation's nursing homes for their care are among the sickest and most vulnerable populations. They frequently depend on extensive assistance in basic activities, such as dressing, grooming, and using the bathroom, and many require skilled nursing or rehabilitative care. The federal government will pay a projected \$39 billion for nursing home care in 1999 and, in partnership with the states, plays a key role in ensuring that nursing home residents receive quality care.

Quality-of-care problems in the nation's nursing homes had gone largely unnoticed until you initiated your recent inquiries, including requesting studies from us, and began your series of hearings and oversight. The Committee's earlier hearings, held in July 1998 and March 1999, called attention to major concerns regarding poor quality of care, inadequate response to complaints alleging serious quality concerns, and the lack of enforcement of Medicare and Medicaid requirements in the nation's nursing homes.

During these hearings, we released three reports that focused on problems in California nursing homes as well as the enforcement and complaint investigation processes nationwide, and made a series of recommendations intended to improve HCFA's role as the principal federal entity responsible for nursing home oversight. Major findings in the three reports include the following:

- One-fourth of the more than 17,000 nursing homes nationwide had serious deficiencies that caused actual harm to residents or placed them at risk of death or serious injury;
- 40 percent of these homes had repeated serious deficiencies;
- the extent of serious care problems portrayed in federal and state data is likely to be understated;
- complaints alleging serious care problems often remain uninvestigated for weeks or months; and
- even when serious deficiencies are identified, state and federal enforcement policies have not been effective in ensuring that the deficiencies are corrected and remain corrected.

HCFA concurred with virtually all of our recommendations and has developed about 30 initiatives to strengthen federal standards, oversight, and enforcement for nursing homes. As you requested, my remarks today will focus on HCFA's progress in implementing these initiatives. In particular, I will discuss

- the overall scope of HCFA's initiatives,
- early implementation experience for initiatives for which HCFA has already issued revised guidance to the states,
- the implications of a proposed expansion of the category of nursing homes that would face more intensive review and immediate sanctions for deficiencies, and
- initiatives that will require a longer-term commitment for HCFA to implement.

In summary, HCFA has undertaken a wide array of changes in its nursing home oversight that can be

summarized in three key areas: (1) strengthening the survey process to be better able to identify violations of federal standards, (2) more strictly enforcing sanctions for nursing homes that do not sustain compliance with these standards, and (3) better educating consumers and nursing home administrators regarding quality of care.

HCFA has provided directives to state agencies on six initiatives, but we found that states have only partially adopted these revised HCFA policies. While in some cases the states have largely implemented these directives, in other cases the directives have not resulted in major changes in state practices because states often indicated they already had similar practices in place, considered the guidance as optional, or lacked the resources to implement certain directives. Furthermore, some of the directives have not had an appreciable effect on the number of homes receiving focused reviews and stricter enforcement.

One of the most controversial changes proposed relates to the revised definition of homes that would be categorized as "poorly performing" and would subject them to immediate sanctions for deficiencies. The revised definition, which HCFA plans to implement later this year, would include homes that have had deficiencies on consecutive surveys involving actual harm to at least one resident--a "G" level deficiency in HCFA's scope and severity lexicon--which previously had not been subject to immediate sanctions. We estimate that if this change in definition had been in effect for the most recent 15-month period ending April 1999, it would have significantly increased the number of homes classified as poorly performing and thus facing stricter enforcement from about 137, or about 1 percent, to 2,275, or 15 percent. Some homes claim that such deficiencies are not sufficiently severe to warrant increased scrutiny and immediate sanctions. Our review of a random sample of over 100 homes that received at least one G-level deficiency found that in virtually all cases the home had a deficiency that represented a serious problem in the nursing home's care that resulted in documented actual harm to at least one resident. These deficiencies most typically included failure to prevent pressure sores, failure to prevent accidents, failure to ensure adequate nutrition, and leaving dependent residents lying for hours in their bodily wastes.

Other HCFA initiatives will require longer-term efforts to develop and implement. For example, HCFA has issued a contract to improve the methodology that state surveyors use to sample residents for intensive review during annual on-site surveys. The improved methodology will use a more rigorous and more targeted sampling technique. This will better enable surveyors to identify potential care problems in nursing homes--including poor nutrition, dehydration, neglect and abuse, and pressure sores--and to determine the prevalence of such problems when they are found. HCFA will soon start providing quality indicator information on homes to surveyors to consider when selecting sample cases. But implementation of a more rigorous sampling methodology that will better permit identifying a problem's prevalence will not take place until mid-2000. Furthermore, while much of HCFA's enforcement and oversight efforts depend on complete, accurate, and timely data, our previous reports highlighted many flaws with its survey and certification management information system. HCFA is still planning the redesign of this system, and implementation of a redesigned system for nursing homes is unlikely before 2002.

BACKGROUND

On the basis of statutory requirements, HCFA, within the Department of Health and Human Services, defines standards that nursing homes must meet to participate in the Medicare and Medicaid programs and contracts with states to certify that homes meet these standards through annual inspections and complaint investigations. The annual survey, which must be conducted no less than once every 15 months at each home, entails a team of state surveyors spending several days on site conducting a broad review to determine whether care and services meet the assessed needs of the residents. HCFA

establishes specific protocols for state surveyors to use in conducting these comprehensive reviews. In addition, when a complaint is filed against a home by a resident, his or her family or friends, the concerned public, or nursing home employees, a complaint investigation may be conducted that involves a targeted review of the specific complaint.

HCFA classifies nursing home deficiencies by their scope-the number of residents potentially or actually affected-and severity-the potential for more than minimal harm; actual harm; or serious injury, death, or its potential ("immediate jeopardy"). Deficiencies are classified in one of 12 categories labeled "A" through "L." The most serious category (L) is for a widespread deficiency that causes death or serious injury or creates the potential for death or serious injury to residents; the least serious category (A) is for an isolated deficiency that poses no actual harm and has potential only for minimum harm. (See table 1.) Homes with deficiencies that do not exceed the C level are considered in "substantial compliance," and as such are deemed to be providing an acceptable level of care.

The federal government has the authority to impose a variety of sanctions if homes are found to have a deficiency, including fines, denying Medicare or Medicaid payment for new or all residents, or ultimately terminating the home from participation in Medicare and Medicaid. The scope and severity of a deficiency determine the types of applicable sanctions and whether they are required or optional. Under their shared contractual responsibility for Medicare-certified nursing homes, state agencies identify and categorize deficiencies and make referrals with proposed sanctions to HCFA. Under HCFA's current policies, most homes are given a grace period, usually 30 to 60 days, to correct deficiencies. States do not refer homes to HCFA for sanctions unless the homes fail to correct their deficiencies within the grace period. Exceptions are provided for homes with deficiencies at the highest level of severity (J, K, or L) and for homes that meet HCFA's definition of a "poorly performing facility"-a special category of homes with repeat serious deficiencies. HCFA policies call for states to refer these homes immediately for sanction. HCFA also provides a notice period of 15 days before a sanction takes effect, and if homes come into compliance during this time, the sanction is waived.

HCFA HAS UNDERTAKEN A BROAD ARRAY OF INITIATIVES IN RESPONSE TO IDENTIFIED CONCERNS

HCFA has undertaken about 30 initiatives intended to improve nursing home oversight and enforcement and has provided monthly status reports to this Committee since last year. HCFA's efforts over the past year can be categorized in three broad categories:

Improved survey processes intended to result in better detection of noncompliance with federal requirements. HCFA has already provided revised guidance to states in some survey process areas, such as requiring them to respond more rapidly to complaints alleging harm to residents and requiring states to begin some of their inspections on weekends or after normal working hours. Over the longer term, HCFA is changing the standard inspection process to focus the sample of residents selected for review on problem areas identified using patient-specific data reported by the nursing home. However, this major change will require time to design the new sampling methodology and train state surveyors in it.

Stricter enforcement aimed at ensuring that nursing homes maintain compliance with federal requirements. HCFA's initiatives include requiring states to conduct more "revisits" to better ensure that homes correct serious deficiencies found in a prior survey and targeting a limited number of nursing homes with particularly poor compliance records for more frequent inspections. In addition, HCFA has proposed broadening the category of homes that are defined as poor performers and thereby not granted a grace period to correct their deficiencies. HCFA has also recently begun expanding the use of civil monetary penalties to apply penalties on a per-instance basis in addition to per day. It is also reevaluating policies relating to terminated homes. This includes developing standards (1) ensuring that

federal payments are made to terminated homes only if they are actively transferring residents to other settings, (2) providing guidance on the appropriate length of a "reasonable assurance period" in which a home demonstrates it has eliminated deficiencies before the home is allowed to reenter the Medicare program, and (3) ensuring that a home's pre-termination compliance history is considered in any subsequent enforcement actions after it has been readmitted.

Better information to track homes' compliance status and assess quality of care as well as to educate consumers and nursing home administrators. HCFA has begun posting the results of recent surveys for each nursing home in the nation on the Internet to enable consumers searching for a nursing home to better distinguish among homes on the basis of quality. In addition, HCFA has initiated educational programs for nursing home administrators to better enable them to meet federal requirements. Examples include developing and posting on the Internet best practice guidelines for caring for residents at risk for weight loss and dehydration and engaging in national efforts promoting awareness on prevention abuse, such as developing educational posters and other materials. Finally, HCFA has embarked on a major redesign of its survey and certification management information systems. This will include a redesign of its management information system-the On-Line Survey, Certification, and Reporting (OSCAR) system-and development of a system to track chain ownership of providers, including nursing homes. These projects are just beginning and will require several years to complete.

STATES HAVE PARTIALLY ADOPTED REVISED HCFA GUIDANCE

Over the past year, HCFA has issued revised directives and guidance to the states implementing several of the survey improvement and enforcement initiatives. In order to determine states' responses to these initiatives and HCFA's monitoring of their implementation, we requested information from each of the 10 HCFA regional offices and the largest state in each region. Some states have revised their practices in response to several of the initiatives. Other states reported that the new HCFA guidance has not resulted in changed practices because they believed existing state practices accomplished similar goals or they chose not to implement the HCFA policy. States also highlighted some concerns or operational difficulties, including resource constraints, associated with specific initiatives. To date, HCFA has conducted only limited monitoring of states' implementation of these initiatives.

Several Initiatives Require States to Significantly Increase Survey Activity

Three of the initiatives that HCFA instructed the states to implement can require a significant increase or modification in states' nursing home survey activity. For each initiative, some of the 10 states we polled indicated that their existing practices were similar to the change required by HCFA and thus they implemented no new practices. States that did not have similar existing practices often cited that resources were a significant barrier to compliance.

Revisits for Serious Deficiencies

In July 1998, we reported that states often accepted homes' self-reports that they had corrected serious deficiencies without performing an independent, on-site follow-up. In some cases, we found that these deficiencies had not been corrected despite the home's self-report. We recommended that, for homes with recurring serious violations, HCFA require state surveyors to substantiate by an on-site review that the home has achieved compliance. In response, HCFA issued a policy letter in August 1998 directing state agencies to perform revisits for all deficiencies where harm to one or more residents was found until the state was assured that the deficiencies were fully corrected.

More than half of the states we contacted informed us that prior to the new HCFA policy they had been

verifying that homes corrected serious deficiencies through a revisit. Additionally, Florida, Massachusetts, and Texas indicated that they had implemented this new policy, and California indicated that it had partially done so. California and Massachusetts reported that this change has led to a sharp increase in the number of revisits they conduct and requires additional resources. As a result, their ability to timely meet requirements for other types of surveys, such as complaint investigations and annual surveys, may be restricted.

Complaints Alleging Actual Harm to Residents

In response to our March 22, 1999, report finding that states often did not investigate serious complaints for weeks or months, HCFA issued a policy letter in March 1999 instructing states to investigate any complaint alleging actual harm within 10 workdays. We found that many states expressed concern that they would need substantial additional resources to implement it. Of the 10 states we contacted, 4 reported that they were meeting this requirement. For example, in response to a state auditor's report, Pennsylvania had begun investigating all complaints within 2 calendar days. Three other states, California, Illinois, and Washington, also had state requirements that serious complaints be investigated within 10 workdays (7 calendar days for Illinois), but California and Washington acknowledged that they were not fully able to investigate all complaints within this time frame without additional resources. Washington, for example, estimated that it would require nine additional surveyors to meet the 10-workday requirement in all cases. The remaining three states—Colorado, Massachusetts, and Missouri—indicated that they had not implemented the more stringent 10-day investigation requirement for complaints alleging actual harm situations, generally indicating that they were awaiting clarification on this policy from HCFA before implementing it. HCFA continues to develop additional guidance for states regarding which complaints should appropriately be considered as alleging actual harm and thereby be investigated within 10 workdays.

Evening and Weekend Surveys

We previously reported that annual surveys are often predictable, allowing nursing homes to prepare for surveys in ways that did not represent the normal course of business or care, and we recommended that HCFA require the states to stagger the starting months of surveys in a way that reduces their predictability. Although HCFA disagreed that surveys are predictable and has not directly acted on this recommendation, it issued instructions effective in January 1999 requiring that 10 percent of annual surveys be started on weekends or outside normal working hours. Because homes are often staffed differently and exhibit different care environments on weekends, evenings, and nights, this initiative is intended to allow state surveyors a better opportunity to identify the actual operating conditions of homes. Eight of the 10 states we contacted indicated that they had fully implemented this new policy. One state noted that it had previously conducted surveys during evening and weekend hours but had not necessarily started the surveys at these times as required by the new HCFA guidance. However, several states also indicated that conducting more surveys during these hours has posed labor issues, including increased overtime pay, and may make it more difficult to recruit or retain surveyors.

Of the two states that had not fully implemented the revised HCFA policy, Texas indicated that existing state policy requires that 20 percent of inspections be done during "off" hours but that this included complaint investigations and permitted a less stringent definition of "off" hours than HCFA's requirement. Pennsylvania had not implemented this HCFA policy, but commented that its aggressive complaint investigation policy has resulted in increased surveillance of nursing homes on weekends, evenings, and holidays.

Recent Initiatives Targeting Poorly Performing Homes Have Focused on Few Additional Homes

Three HCFA initiatives were intended to enhance monitoring of, and impose more immediate sanctions on, homes with records of poor performance. However, to date, these initiatives have not significantly increased the number of homes receiving closer scrutiny. The impact of these initiatives has been limited because the first was designed to target only a small number of homes; the second, partially implemented initiative has not yet significantly changed the number of homes considered poorly performing; and the third was optional, and most states chose not to implement it.

Special-Focus Facilities

In January 1999, HCFA implemented its program for enhanced monitoring of 100 "special-focus" nursing homes-two per state-with records of poor care. HCFA identified four homes in each state with persistently poor compliance records, and each state agency was expected to select two of these homes for enhanced monitoring, including conducting standard surveys every 6 months rather than annually. Although worthwhile, the very narrow scope of this initiative excluded many homes providing poor care.

All 10 states we contacted indicated that they had begun enhanced monitoring of the special-focus facilities in their state. Several indicated that the additional resources required to focus on two homes were minimal. However, some states questioned HCFA's selection criteria and indicated that they would have identified homes other than those identified by HCFA as more appropriately warranting increased scrutiny. Some also suggested that HCFA should develop clear criteria as to when a home should no longer be considered a special-focus facility and replaced by another selected for focused monitoring. Also, a HCFA regional office questioned the appropriateness of having an equal number of homes per state, regardless of a state's total number of nursing homes. For example, Washington, with 284 homes, is focusing on the same number of homes as Alaska, which has 15 homes. Two states noted that they had begun increased monitoring of a larger number of homes: Illinois intends to include all 4 HCFA-suggested homes in its enhanced monitoring efforts, and California indicated that it had identified 34 nursing homes for increased survey activity.

Redefinition of Poorly Performing Homes

In July 1998, we recommended that, for homes cited for repeated serious violations, HCFA eliminate the grace period in which homes were allowed to correct deficiencies without a sanction being imposed. In September 1998, HCFA modified its former policy accordingly by expanding its definition of a poorly performing facility to include those with recurring actual harm deficiencies. However, HCFA initially included only recurring actual harm deficiencies that involved a pattern or were widespread in scope (H-level or higher). HCFA postponed including homes with isolated actual harm deficiencies (G-level) in two consecutive surveys when it recognized that the number of homes designated as poor performers and the associated costs to states of dealing with them would increase significantly. Thus, HCFA currently considers any home a poorly performing facility if it had been cited with a deficiency for a pattern of actual harm to several residents (H-level) or worse in two consecutive annual surveys or any intervening revisit or complaint investigation. Nursing homes given this designation are automatically denied an opportunity to correct deficiencies before sanctions are applied and are referred immediately to HCFA for sanction.

Eight of the 10 states we contacted said that they had implemented the policy including recurring H-level and higher deficiencies. Most of these states indicated that the revision has not significantly changed the number of nursing homes designated as poorly performing. Our analysis of HCFA data nationwide also indicated that the new definition, if it had been in effect for the 15-month period prior to April 1999, would have actually reduced slightly the number of homes meeting the definition of poor performers from about 146 homes to 137 homes (about 1 percent of homes). Of the two states that had

not implemented the interim HCFA guidance, California reiterated that it has implemented its own focused enforcement program for 34 homes with a poor compliance history, and New York, while it is not complying with this requirement, said that it is using the new HCFA criteria to impose state fines.

Poorly Performing Chains

Also in September 1998, HCFA issued interim guidance to states allowing but not requiring them to immediately refer chain-owned homes with actual harm deficiencies for sanctions if any of the chain's homes had poor performance records. Of the 10 states we contacted, only Pennsylvania indicated that it had implemented this guidance, and Massachusetts and Florida said that they had "partially" implemented it because they were already taking some action against problem nursing home chains. However, none of the three states had referred any homes to HCFA for sanctions because they belonged to poorly performing chains. Some states, such as California and Florida, indicated that they are using other approaches, such as denying state licensure, to limit chains with poor compliance records from expanding in their states. The other states indicated that they chose not to implement this guidance or found HCFA's guidance to be unclear and were awaiting further clarification of HCFA's policy. Some were concerned that referrals to HCFA that are based partially on the performance of other homes, even with common ownership, are unfair or that the practice could lead to increased informal dispute resolution requests by homes.

One significant barrier to implementing this initiative is that HCFA is unable to reliably identify homes that belong to nursing home chains and does not keep statistics on nursing home enforcement actions according to ownership. HCFA estimates that ownership information will not be consistently and completely tracked for several years.

HCFA Does Not Consistently Monitor State Implementation of Its New Policies

HCFA's 10 regional offices are charged with monitoring state implementation of its policies and directives related to enforcement of federal nursing home requirements. When we asked the regional offices how they were monitoring states' implementation of these initiatives, their responses ranged from no monitoring of most of the implemented initiatives to requiring states to submit special reports. For example, the Dallas regional office stated that it does not routinely monitor state implementation of any of these HCFA initiatives. The Denver regional office said that it was monitoring most of these initiatives through the normal course of business. In contrast, the Boston regional office said that it was requiring states in its region to submit monthly reports on how they were implementing several of these initiatives.

Because of these uneven monitoring practices, HCFA is not well informed on what the states are doing with regard to these initiatives. For example, all regions reported to the HCFA central office that the states in their region had implemented instructions to reduce the predictability of surveys. However, as noted, of the 10 states we contacted, one indicated that it had not implemented, and another said that it had partially implemented, this policy. Furthermore, a HCFA central office official told us that, although the regional offices had reported that all states had implemented this policy, the board of the Association of Health Facility Survey Agencies, representing the state survey agencies, had told HCFA that 12 states had not done so. A HCFA official acknowledged that no action has been taken regarding states that have not complied with HCFA's initiatives.

PROPOSED EXPANSION OF "POOR PERFORMER" CATEGORY IS CONTROVERSIAL BUT HAS MERIT

HCFA's proposed expansion of the definition of a poorly performing facility to include homes with G-level deficiencies in two consecutive annual surveys or an intervening survey would greatly increase the number of poorly performing homes that are immediately referred to HCFA for sanction without a grace period to correct deficiencies. If this revised definition had been in effect for the most recent 15-month period ending April 1999, we estimate that nearly 15 percent of all homes nationwide, or 2,275 homes, would have been subject to immediate sanction, compared with about 1 percent under the current definition. Industry representatives contend that the proposed definition would inappropriately penalize homes, because G-level deficiencies are often less serious problems not involving harm to residents. However, on the basis of our review of the G-level deficiencies in over 100 surveys of randomly selected homes with such deficiencies, we found that the vast majority appropriately documented actual harm to at least one resident.

Of the 107 surveys with G-level deficiencies that we reviewed, 98 percent (all but 2 surveys) involved care or lack of care that harmed residents. Most commonly, these deficiencies related to failure to prevent pressure sores (23 percent); accidents that resulted in fractures, abrasions, or other injury (14 percent); poor nutrition (8 percent); abuse (4 percent); or other quality-of-care concerns (6 percent). Quality-of-life deficiencies, such as failing to protect resident dignity and rights to self-determination, were found to have harmed residents in about 4 percent of these deficiencies. Of the 107 homes with G-level deficiencies we reviewed, about two-thirds would have been categorized as a poorly performing facility if the proposed redefinition had been in effect in 1998.

Some states are concerned that the broader definition could result in increased enforcement activity, and more actual harm deficiencies being contested through the informal dispute resolution process and subsequent sanctions being appealed to the Department of Health and Human Services' Departmental Appeals Board. However, our analysis suggests that almost all G-level deficiencies in fact involve documented harm to residents, justifying increased enforcement activity for homes with a history of them. For those few cases where harm to the resident is uncertain, mechanisms exist for homes to request reconsideration of the initial surveyor's deficiency citations.

SEVERAL KEY INITIATIVES WILL REQUIRE HCFA'S LONG-TERM COMMITMENT

Several HCFA initiatives will require a longer-term commitment to fully implement than those just discussed. These initiatives involve major changes to HCFA's nursing home survey process to enhance its ability to detect and estimate the prevalence of serious quality-related deficiencies and the enhancement of HCFA's management information system to enable better tracking of homes' compliance histories. While these reforms are critical for improving the effectiveness of HCFA's oversight and setting accurate baseline measures of nursing home quality, their complexity means that these initiatives will not be implemented until next year or several years thereafter.

Redesign of Survey Process Entails Several Components

HCFA has begun a major redesign of its nursing home survey process. A considerable portion of a nursing home's survey has involved selecting a sample of residents for focused review of their quality of care. This review may include examination of medical records, physical observation, and, where possible, resident interviews. In an earlier report to this Committee, we found that HCFA's surveys included too few residents not randomly selected, thereby precluding surveyors from easily determining the prevalence of identified problems. The inability to estimate prevalence makes it difficult for surveyors and state agencies to determine where a cited deficiency should fall in HCFA's nursing home deficiency scope and severity grid, which in turn determines whether a nursing home is offered an opportunity to correct before sanctions are applied and the level of sanctions. We recommended that HCFA revise its survey procedures to instruct inspectors to take stratified random samples of resident

cases and review sufficient numbers to permit surveyors to better detect problems and assess their prevalence.

In response to our recommendation, HCFA has begun modifying the sampling methodology of its nursing home survey protocol. This change has two parts. First, effective July 1, HCFA will provide surveyors with quality indicators that include comparative information on areas such as nutrition, hydration, and pressure sores. It will also increase the sample size in areas of particular concern, including nutrition, dehydration, and pressure sores. However, the sample will continue to be nonrandom and in large part based on the judgment of the surveyors.

The second stage of this change will introduce a more rigorous sampling methodology, incorporating the quality indicators and other data derived from medical records in a two-stage sampling process designed to identify areas in which the nursing home departs significantly from the average of other homes. The methodology will target these areas for focused sampling and permit surveyors to make a reliable estimate of the prevalence of quality-of-care problems identified in the nursing home. This second stage is to be implemented during 2000. We believe that implementation of this stage is necessary for HCFA to fully respond to our recommendation and significantly improve the ability of surveys to effectively identify the existence and extent of deficiencies.

Redesign of HCFA's Management Information System Will Require 3 Years

In a recent report, we recommended that HCFA develop an improved management information system, which would help it track the status and history of deficiencies, integrate the results of complaint investigations, and monitor enforcement actions. In response to this recommendation, HCFA embarked on a 3-year project to redesign its on-line management information system, the OSCAR system. This project is in its preliminary phase, with a contractor gathering broad requirements for what the system will be required to do as a first step in creating a system design. Initially, this new system will be brought on-line for a single provider type-home health agencies-and subsequently expanded to other providers, with nursing homes projected to come on-line second by the beginning of 2001. The final stage will be to link this system with other HCFA quality-related databases, such as the Minimum Data Set for nursing homes, by the end of January 2002.

The Minimum Data Set is potentially a key source of information for tracking changes in quality of care. However, these data have some limitations, particularly in the short term. Because the reporting of these data has begun only recently, reporting is not consistent, and most states lack a baseline for comparison. Also, these data are self-reported by nursing homes and are used to adjust Medicare payments for level of care as well as serve as the basis for the quality indicators now being incorporated into the nursing home inspection process. These multiple uses create a complex set of reporting incentives for nursing homes, which suggests that unaudited information from the Minimum Data Set should be treated with caution as a data source for tracking quality changes. Our earlier work indicated that nursing homes' medical records often inaccurately portray patient quality of care, suggesting that the Minimum Data Set information also may not accurately reflect quality issues.

In addition, HCFA plans to develop a database that will track nursing home ownership to permit better identification of chains. However, a HCFA official told us that HCFA cannot even begin to design this system until it develops the congressionally mandated national provider ID system, which will give each Medicare-certified provider a distinct tracking number. Implementation of an ownership tracking system is thus several years away.

CONCLUDING OBSERVATIONS

During the last year, increased congressional and administration attention to the inadequate care provided for many nursing home residents has resulted in significant efforts to improve conditions. Some HCFA initiatives have already been implemented, such as providing consumers with nursing home compliance information on the Internet, increasing the number of state surveys beginning on evenings and weekends, and allowing civil monetary penalties to be imposed for each instance of a violation. However, many other efforts are still in process and will require HCFA's further effort and commitment to complete. Also, since HCFA must depend on the states to implement many of these efforts, it will need to monitor state implementation to ensure that implementation is consistent and in line with HCFA's intentions. HCFA must further rely on the partnership between states and HCFA's regional offices to effectively implement its initiatives and monitor progress. But, at present, this is complicated by inconsistencies in the monitoring practices of the regional offices. At your request, we are now examining HCFA's regional office oversight of state agency performance in certifying nursing homes.

The purpose behind all these initiatives is, naturally, improvement of the care given to nursing home residents. Such improvements are difficult to measure, especially in the short run. Tracking the results of nursing home surveys, particularly in quality of care deficiencies such as pressure sores, nutrition, dehydration, and abuse, can potentially provide some insights. However, the changes being made in the survey process are intended to result in improved and more consistent detection of quality problems, potentially increasing the number reported. Thus, improvements to the survey methodology could create a false impression that quality of care is getting worse instead of better, because HCFA and the states will be better able to identify and document deficiencies. Nonetheless, these initiatives are important steps toward improving the quality of care America's nursing home residents receive. If well implemented, the initiatives should improve the effectiveness of the survey process, strengthen the enforcement process, enhance HCFA's management information systems, and provide better information to consumers and nursing home administrators. While in the short run it may be difficult to assess the degree to which these changes improve care to nursing home residents, over the long run HCFA and the Congress will be better able to monitor the care nursing home residents receive and determine what additional improvements are necessary. Continued commitment and oversight are also important elements of the endeavor to improve nursing home quality of care.