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**MEDICARE AND
MEDICAID
PARTICIPATING
FACILITIES**

**CMS Needs to
Reexamine Its
Approach for Funding
State Oversight of
Health Care Facilities**



GAO

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Highlights of [GAO-09-64](#), a report to congressional requesters

Why GAO Did This Study

Americans receive care from tens of thousands of health care facilities participating in Medicare and Medicaid. To ensure the quality of care, CMS contracts with states to conduct periodic surveys and complaint investigations. Federal spending on such activities totaled about \$444 million in fiscal year 2007; states are expected to contribute their own funds both through the Medicaid program and apart from that program. GAO evaluated survey funding, state workloads, and federal oversight of states' use of funds since fiscal year 2000 to determine if federal funding had kept pace with the changing workload. GAO analyzed (1) federal funding trends from fiscal years 2000 through 2007 and CMS's methodology for determining states' allocations and spending, (2) CMS data on the number of participating facilities and completed state surveys, and (3) CMS oversight of state spending. GAO interviewed state officials and collected data from 28 states.

What GAO Recommends

GAO recommends that CMS consider several actions to address survey funding weaknesses, such as state funding inequities, limited data on the impact of funding on facility oversight, and limited oversight of state spending. GAO also recommends that CMS broadly reexamine its current approach to funding and conducting surveys. CMS and state officials disagreed with elements of GAO's workload analysis but CMS concurred with 9 of GAO's 10 recommendations and partially concurred with the other.

To view the full product, including the scope and methodology, click on [GAO-09-64](#). For more information, contact John Dicken at (202) 512-7114 or dickenj@gao.gov.

MEDICARE AND MEDICAID PARTICIPATING FACILITIES

CMS Needs to Reexamine Its Approach for Funding State Oversight of Health Care Facilities

What GAO Found

Federal funding for state surveys increased from fiscal years 2000 through 2002 but was nearly flat from fiscal years 2002 through 2007. In inflation-adjusted terms, funding fell 9 percent from fiscal years 2002 through 2007. CMS has made incremental adjustments to improve its management of state allocations. It shifted federal funding from support contracts to surveys, increasing state allocations about 1 percent in fiscal years 2006 and 2007. For some facilities without statutory survey frequencies, CMS increased the time between surveys from 6 years to 10 years—a schedule that may further increase the chance of undetected quality problems. CMS also developed a budget analysis tool to help address the mismatch between federal allocations and states' current survey workloads, but use of the tool has been limited.

Most states, including those that spent more than their initial federal allocations, did not complete CMS's survey workload priorities in fiscal years 2006 and 2007, though the required survey workload—the workload that states would have to complete to meet statutory and CMS survey frequency requirements—decreased about 4 percent nationwide from fiscal years 2000 to 2007. A decrease in the number of the most time-consuming and frequently surveyed facilities, such as nursing homes, offset the increase in other facilities. CMS lacked consistent and reliable data to measure workload changes in other areas such as complaint investigations. States reported that workforce instability due to noncompetitive surveyor salaries and hiring freezes hindered their workload completion but CMS has little influence over state hiring. Among seven states that completed their nursing home surveys, CMS found that 25 percent or more of some of their surveys missed serious deficiencies. According to CMS, the performance of one of these states raised concerns about the state's management of survey activities.

There is little oversight of state non-Medicaid contributions intended in part to reflect the benefit states derive from participating in federally sponsored oversight of facilities. State contribution rates have not been reviewed in recent years. CMS officials told GAO that the agency does not collect information on state expenditures to help ensure that states are contributing funds consistent with those rates, noting limits on their authority to require submission of such data. CMS believes, however, that federal funding may not be sufficient and that state spending above the initial Medicare allocation represents state funds in addition to the non-Medicaid share.

The evidence is mixed on whether federal funding has kept pace with the changing workload. The required survey workload decreased nationwide but most states told GAO that survey frequencies of 6 to 10 years for many facilities could adversely affect beneficiaries. Moreover, distinguishing the impact of funding, staffing, and management on state workloads is difficult. GAO believes that these and other weaknesses in CMS's current funding approach will continue to frustrate the agency's efforts to support and oversee state survey activities.

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Abbreviations

AHFSA	Association of Health Facility Survey Agencies
CMS	Centers for Medicare & Medicaid Services
HHS	Department of Health and Human Services
OIG	Office of Inspector General
OSCAR	On-Line Survey, Certification, and Reporting system
PDQ	Providing Data Quickly
QIS	Quality Indicator Survey
RN	registered nurse

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United States Government Accountability Office
Washington, DC 20548

February 13, 2009

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

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

In 2007, millions of Americans received care from tens of thousands of health care facilities—including nursing homes, hospitals, dialysis facilities, and home health agencies—that participate in the Medicare or Medicaid programs.¹ To ensure that these facilities provide high-quality care in a safe environment, the Centers for Medicare & Medicaid Services (CMS) contracts with state survey agencies to conduct periodic inspections known as surveys and complaint investigations and to initiate enforcement actions against facilities that fail to comply with federal standards.² Federal Medicare and Medicaid expenditures on such survey activities totaled about \$444 million in fiscal year 2007.³

We have reported concerns about state survey activities and CMS oversight for the past 10 years.⁴ In 1998 and 1999, we found significant weaknesses in federal and state survey activities designed to detect and correct quality problems in nursing homes, such as the failure to promptly investigate complaints of alleged serious care problems or to conduct on-

¹Medicare is the federal health care program for elderly and certain disabled individuals. Medicaid is a joint federal-state health care financing program for certain categories of low-income individuals.

²CMS is an agency within the Department of Health and Human Services (HHS). Throughout this report, we refer to state survey agencies, including the District of Columbia agency, as “states.”

³States also contribute a state share of Medicaid funds and non-Medicaid funds in support of survey activities. State non-Medicaid contributions are to reflect the benefit states derive from health care facilities meeting federal quality standards as well as the cost of assessing compliance with state licensing requirements.

⁴See a list of related GAO products at the end of this report.

site revisits to verify that nursing homes corrected serious deficiencies.⁵ CMS responded by establishing a set of initiatives, known as the Nursing Home Oversight Improvement Program, intended to address many of those weaknesses. For fiscal year 1999, the budget for survey activities was significantly increased to support the associated workload growth. While nursing homes make up about 25 percent of facilities that participate in Medicare and Medicaid, they accounted for about three-fourths of federal spending on survey activities in fiscal year 2007. In December 2005, we reported CMS's concern that funding for survey activities had not kept pace with the growth in survey workloads due to the increase since 2000 in the number of facilities that participate in Medicare and Medicaid and CMS initiatives to improve nursing home oversight.⁶

You asked us to undertake a broad evaluation of the funding of survey activities since fiscal year 2000. Specifically, we examined (1) the trends in federal funding for survey activities and how CMS has managed the allocation of these funds, (2) the extent to which states have completed their survey workload and the factors that affected workload completion, and (3) the effectiveness of CMS's oversight of states' use of funds for survey activities.

To examine federal funding trends and CMS's allocation of federal funds since 2000, we analyzed or reviewed (1) the President's budget request; (2) federal funding for survey activities from fiscal years 2000 through 2008; (3) data on actual state survey expenditures; and (4) documentation on the process CMS uses to allocate funds to states (known as the budget allocation process), including the budget analysis tool developed in 2005 to help determine state funding allocations.⁷ We did not, however, evaluate the effectiveness of the tool. We also discussed the management of the budget allocation process with CMS central office and regional office staff and obtained the perspective of survey agency officials from 28 states,

⁵GAO, *California Nursing Homes: Care Problems Persist Despite Federal and State Oversight*, [GAO/HEHS-98-20](#) (Washington, D.C.: July 27, 1998) and *Nursing Homes: Complaint Investigation Processes Often Inadequate to Protect Residents*, [GAO/HEHS-99-80](#) (Washington, D.C.: Mar. 22, 1999).

⁶GAO, *Nursing Homes: Despite Increased Oversight, Challenges Remain in Ensuring High-Quality Care and Resident Safety*, [GAO-06-117](#) (Washington, D.C.: Dec. 28, 2005).

⁷We used the gross domestic product price index to adjust for inflation during this time period.

which we selected based on five factors, including state spending trends and ability to complete survey workloads. Our data collection focused on information covering fiscal years 2000 through 2007; except where otherwise reported, 2007 was the year with the most recently available data.

To examine states' completion of survey workload and factors affecting states' ability to complete their survey workload, we analyzed data from CMS's annual state performance reviews for fiscal years 2006 and 2007 and used CMS's On-Line Survey, Certification, and Reporting (OSCAR) system for fiscal years 2000 and 2007.⁸ We used OSCAR data to measure states' required survey workload—the workload that states would have to complete to meet statutory and CMS survey frequency requirements—by taking into consideration the number of facilities, required survey frequencies, and average survey hours by facility type. Because OSCAR only stores data on the four most recent surveys, we obtained survey hours for all facility types from CMS for fiscal years 2000 through 2007. We could not include in our calculations the workload impact of complaint investigations or revisits intended to ensure that serious deficiencies had been corrected because CMS data were either not available or not consistently reported over time. We also discussed workload changes and completion rates with CMS and state officials. In addition, we used CMS data on the quality of state surveys to examine the relationship between workload completion, state spending, and states' ability to identify all serious deficiencies at the time of a state survey.⁹

To examine the effectiveness of CMS oversight of states' use of survey funding, we reviewed CMS guidance to regional offices and states on how state spending should be monitored, periodic state spending reports from several of the 28 states we contacted, and state spending audits conducted by the Department of Health and Human Services (HHS) Office of Inspector General (OIG). We also interviewed CMS central office officials and staff in five CMS regions. For a more detailed description of our scope and methodology and our state selection criteria, see appendix I.

⁸Data on the number of facilities were from December in fiscal years 2000 and 2007.

⁹Throughout this report, we use the term serious deficiency to refer to (1) a deficiency in a nursing home that results in actual resident harm or places residents at risk of death or serious injury, or (2) a deficiency at other facility types that adversely affects or has the potential to adversely affect patients.

Throughout the course of our work, we discussed our analysis of OSCAR data and other data provided by CMS with CMS officials to ensure that the data accurately reflected state survey activities. We also tested the information provided by the states for completeness and consistency. We determined that these data sources were valid and reliable for our purposes. We conducted this performance audit from June 2007 through February 2009 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Under contract with CMS, states survey 13 types of health care facilities that participate in Medicare and Medicaid; in 2007, there were about 60,000 such facilities. State survey activities are primarily funded by the federal government.¹⁰ Other types of facilities that participate in Medicare and Medicaid are also subject to surveys, but the surveys are not always conducted by states or are not federally funded. For example, community mental health centers are surveyed by federal surveyors located in each of CMS's 10 regional offices rather than state surveyors. Four facility types—ambulatory surgical centers, home health agencies, hospices, and hospitals—can choose to be surveyed by accrediting organizations, such as the Joint Commission, instead of states.¹¹ However, facilities that choose this option are charged fees and are subject to state validation surveys that assess how well the accreditation process detects

¹⁰In general, obtaining a state license to operate is a prerequisite for a facility to participate in Medicare and Medicaid. However, states do not necessarily license every facility that participates in federal health care programs. For example, Florida and Washington do not license end-stage renal disease facilities and Ohio does not license hospitals.

¹¹By law, CMS is authorized to enter into agreements with states to survey a selective sample of accredited hospitals or individual accredited hospitals where there are allegations of serious deficiencies. 42 U.S.C. § 1395aa(c).

deficiencies in compliance with Medicare quality standards.¹² Clinical labs are unique in that CMS collects fees from the labs to cover the cost of state surveys and federal oversight, including state validation surveys of a sample of accredited labs.¹³

Survey Frequency

Survey frequencies for nursing homes, intermediate care facilities for the mentally retarded, and home health agencies are established by federal statute, range from about 1 to 3 years, and are defined as **maximum** time intervals between surveys. In contrast, CMS sets survey frequencies for the 10 other facility types that states survey as a matter of policy (see table 1). These frequencies are typically every 6 years or more and they have generally been defined as the **average** across all facilities of the same type (see app. II). As a result of CMS's reliance on averages, some facilities could be surveyed earlier and others later and still meet the agency's frequency standard. CMS distinguishes, however, between (1) its policies on survey frequency, and (2) the survey frequencies that it holds states accountable to meeting each year in its state performance reviews (discussed below), which may be less frequent than those established by policy. Although its policies on survey frequency change infrequently, CMS officials told us that nonstatutory survey frequencies are resource driven and depend on each year's funding level. For example, CMS policy for most nonstatutory survey frequencies has been about 6 years since fiscal year 2001; based on available resources, however, the survey frequencies for which CMS has held states accountable have ranged from 3.5 years to 10 years from fiscal years 2006 through 2008 (see app. II).¹⁴ In fiscal year

¹²There are two types of state validation surveys that evaluate accreditation organizations' ability to ensure facilities' compliance with Medicare quality standards: (1) representative sample surveys, which are standard surveys conducted shortly after an accreditation organization survey in order to assess the accreditation organization's survey process, and (2) complaint surveys, which are used to identify the compliance of the accredited facility with selected regulatory requirements noted in the complaint received by CMS. Serious deficiencies identified in validation surveys result in the facility's placement under state survey jurisdiction until another state survey verifies that the facility has returned to substantial compliance with Medicare quality standards or the facility is terminated from the Medicare program.

¹³See GAO, *Clinical Lab Quality: CMS and Survey Organization Oversight Should Be Strengthened*, GAO-06-416 (Washington, D.C.: June 16, 2006).

¹⁴CMS's *Mission and Priority Document* communicates the survey frequencies used to determine states' workload as a part of establishing annual priorities for states' required survey workload. Before fiscal year 2006, this document was called the *Survey and Certification Budget Call Letter*.

2003, CMS introduced a 4-tier structure for prioritizing surveys with tier 1 being the highest priority—facilities with statutorily mandated survey frequencies—and tier 4 the lowest priority. CMS instructs states to ensure that tiers 1 and 2 will be completed as a prerequisite for planning surveys in subsequent tiers.

Table 1: Facility Types Whose State Survey Frequencies Are Established by Statute and CMS

Type of facility
<i>Survey frequency established by statute</i>
Home health agency ^a
Intermediate care facility for the mentally retarded
Nursing home
<i>Survey frequency established by CMS</i>
Ambulatory surgical center ^a
Comprehensive outpatient rehabilitation facility
End-stage renal disease facility
Hospice ^a
Hospital ^a
Organ transplant centers ^b
Outpatient physical therapy provider
Portable X-ray service
Psychiatric residential treatment facility ^c
Rural health clinic
Validation surveys for accredited providers ^d

Source: CMS.

^aHome health agencies, ambulatory surgical centers, hospices, and hospitals can choose to be inspected by an accrediting organization, such as the Joint Commission, or by states. The following percentage of each facility type was subject to state surveys in 2007: ambulatory surgical centers (78 percent), home health agencies (86 percent), hospices (85 percent), and hospitals (33 percent).

^bIn 2007, CMS issued a regulation that requires organ transplant center programs to be surveyed. These surveys will be phased in over a 3-year period, beginning in 2007.

^cStates conduct validation surveys to ensure that psychiatric residential treatment facilities are in compliance with attestations concerning the use of restraints.

^dStates conduct two types of validation surveys of accredited facilities to evaluate accreditation organizations' ability to ensure facilities' compliance with Medicare quality standards: (1) representative sample surveys, and (2) complaint surveys.

Survey Activities

States undertake a variety of survey activities, including standard and validation surveys, complaint investigations, revisits, and enforcement actions.¹⁵ Surveys and complaint investigations are conducted to determine facility compliance with federal quality and safety standards.¹⁶ The quality-of-care component of a survey focuses on assessing the facility's compliance with all regulatory requirements, other than the requirements pertaining to protection from fire. It involves direct observation of the provision of care to a sample of patients or residents; interviews of a sample of patients or residents; and review of patient or resident medical records, as well as other facility documents. The safety component of a survey examines a facility's compliance with federal fire safety standards. Complaint investigations allow state surveyors to intervene promptly if problems arise between standard surveys or at accredited facilities. Compared to surveys, complaint investigations are (1) more targeted because they focus on specific concerns, and (2) less predictable because they depend on the number and seriousness of the allegations. For example, some complaints involve potential immediate jeopardy to patient health and safety and must be investigated within 2 to 5 working days. Less serious complaints must be investigated promptly or, in the case of accredited facilities, within 45 calendar days. Moreover, when a complaint investigation identifies a serious deficiency at an accredited facility, an intermediate care facility for the mentally retarded, or a home health agency, a full or extended survey must be conducted.

Deficiencies identified during a survey or complaint investigation are categorized according to their severity. States conduct revisits to ensure that facilities correct any serious deficiencies identified by state surveyors; revisits may also be conducted to determine when a nursing home has returned to compliance and an enforcement action known as a sanction may be ended. On the basis of state recommendations, CMS may implement a sanction when surveyors identify serious deficiencies in a facility's compliance with federal standards.¹⁷ The nature of the care

¹⁵In this report we use the term surveys to refer only to standard and validation surveys.

¹⁶A state may conduct one survey to meet both federal and state licensing requirements.

¹⁷For nursing homes, CMS has a range of sanctions to help encourage compliance with quality requirements ranging from less severe sanctions, such as indicating the specific actions needed to address a deficiency and providing an implementation time frame, to those that can affect a home's revenues and provide a financial incentive to return to and maintain compliance. For many facility types, however, the only available federal sanction is termination from participation in the Medicare and Medicaid programs.

provided by a facility influences the type of expertise needed to conduct surveys. For example, nursing home survey teams primarily consist of registered nurses (RN) and social workers. Surveys of intermediate care facilities for the mentally retarded, on the other hand, call for the skills of a developmental disabilities specialist.

Funding for State Survey Activities

In general, state survey activities are funded through a combination of Medicare, Medicaid, and non-Medicaid state funds.¹⁸ Typically, almost 60 percent of federal spending on survey activities comes from Medicare, with the remaining 40 percent funded by the federal Medicaid share.¹⁹ Salaries, particularly surveyor salaries, are the most significant cost component of state survey activities. Table 2 shows how the two programs fund survey activities for each type of facility. Nursing homes are the only facility type whose surveys are funded by both Medicare and Medicaid.

¹⁸As noted, clinical labs pay for the cost of state surveys and federal oversight.

¹⁹See 42 U.S.C. § 1395aa(b), which directs the Secretary to pay states the reasonable cost of carrying out survey activities and for Medicare's fair share of costs related to Medicare facilities.

Table 2: Funding Source for Survey Activities by Type of Facility

Funding source	Type of facility
Medicare	Ambulatory surgical center
	Comprehensive outpatient rehabilitation facility
	End-stage renal disease facility
	Home health agency
	Hospice
	Hospital
	Nursing home ^a
	Organ transplant centers
	Outpatient physical therapy provider
	Portable X-ray service
	Rural health clinic
	Medicaid
Nursing home ^a	
Psychiatric residential treatment facility	

Source: CMS.

^aMost nursing homes participate in both Medicare and Medicaid and their surveys are funded equally by both programs. Surveys of nursing homes that participate only in Medicare or participate only in Medicaid are funded by each program, respectively.

- **Medicare.** Medicare funding for survey activities is requested and provided as part of a lump sum appropriation for the CMS Program Management Account, which generally funds CMS operations.²⁰ For each fiscal year, CMS develops a budget request for that account, including an amount for survey activities, giving priority to funding for statutory requirements. In determining the amount for survey activities, CMS considers three factors: the number of facilities; the number of surveys states need to conduct, as determined by the established survey frequencies; and the cost of surveys, using the number of hours to complete them as a proxy. The request is submitted to Congress as part of the President’s proposed budget. In the annual appropriations act for HHS, Congress authorizes the transfer of a specific amount from the Medicare Trust Funds to CMS’s Program Management Account, which limits the amount of money that CMS can

²⁰A lump sum appropriation is available for a wide array of purposes and leaves an agency discretion with respect to the distribution of the funds among those purposes.

use for operations, including survey activities.²¹ Typically, tables within the conference report identify amounts for survey and other activities funded through the Program Management Account. According to a CMS official, the agency generally allocates the amounts specified in the conference report tables to the relevant activities.²² Funding for survey activities covers (1) state survey operations; (2) direct federal surveys, such as community mental health centers; and (3) support contracts, such as for training surveyors, developing a new nursing home survey methodology, and surveying psychiatric hospitals.²³ The costs of managing survey activities, such as salaries for staff of CMS's Survey and Certification Group and federal surveyors in each of CMS's 10 regional offices, are also funded through CMS's Program Management Account, but not as part of the funds designated in the conference report for survey activities.

Each August, CMS notifies states of their projected Medicare budget allocations for the federal fiscal year starting October 1, based on the President's proposed budget. After enactment of the appropriations act, the agency notifies states of any changes in their Medicare allocations for survey activities. At the end of the federal fiscal year, CMS may provide supplemental funds to states that spent more than their initial Medicare allocations by redistributing funds from states that spent less than their allocations.²⁴

- Medicaid.²⁵ For surveys of facilities funded by Medicaid, states generally pay 25 percent of the costs and the federal government pays the remaining

²¹ Medicare income in excess of spending is held in the Medicare Trust Funds and invested in federal government securities. The appropriations act also authorizes CMS to credit the account with amounts collected under various authorities and, therefore, to use those amounts for its operations.

²² CMS generally has the authority to reprogram funds within the Program Management Account, that is, adjust the allocation of funds among the various activities. Reprogramming above certain amounts requires advance notice to House and Senate Committees on Appropriations. A CMS financial management official told us that such reprogramming is rare.

²³ CMS recognizes that many states do not maintain the psychiatric expertise necessary to survey these facilities. As a result, CMS contracts with a panel of psychiatric consultant surveyors to survey psychiatric hospitals.

²⁴ States generally rely on their own funds when they spend more than their initial federal Medicare allocations on survey activities and may be reimbursed when CMS redistributes Medicare funds from states that spent less than their allocations.

²⁵ References to federal Medicaid funding in this report represent government *expenditures* that match state Medicaid expenditures.

75 percent.²⁶ The President's budget proposal provides Congress with an estimate of Medicaid spending for survey activities based on projected workload. The annual appropriations act for HHS includes an amount for the federal share of Medicaid expenditures, including states' expenditures for survey activities. Funds are provided to states based on claims submitted for survey activities or state estimates of activities to be conducted.

- Non-Medicaid state funding.²⁷ While states contribute to survey activities by paying 25 percent of Medicaid-covered expenditures, states are also expected to contribute funds for (1) the benefit they derive from facilities meeting federal quality standards and (2) the survey costs associated with state licensing requirements. According to CMS guidance, if the survey of a Medicare facility covers 100 standards and the state has adopted 50 of them for licensing purposes, the state and Medicare would contribute equally to the survey costs of the 50 shared standards and Medicare would cover all the survey costs for the 50 Medicare-only standards.²⁸ If state survey requirements are more stringent than federal requirements—for example, federal requirements call for a facility type to be surveyed every 3 years but a state mandates surveys every 18 months—the state is expected to pay for the additional surveys. Moreover, if a state has no licensing requirements for a facility type, the state still acquires a derived benefit from that facility's having to adhere to federal standards because of its participation in Medicare and Medicaid.

Oversight of States' Performance and Use of Funds

Through staff in its 10 regional offices, CMS oversees the extent to which states' performance ensures that facilities participating in Medicare and Medicaid provide high-quality care in a safe environment. The agency's primary oversight tools are annual performance reviews that measure states' compliance with specific standards and statutorily required federal monitoring surveys of nursing homes to assess the adequacy of state

²⁶ 42 U.S. C. § 1396b(a)(2). This cost sharing differs from cost sharing applicable to federal reimbursement for states' Medicaid expenditures for services, which are determined by a statutory formula. Federal financial participation is not available for any expenditures that are attributable to the state's overall responsibilities under state law and regulations for establishing and maintaining standards. 42 C.F.R. § 431.610(h) (2008).

²⁷ Throughout this report, we refer to state funds that are in addition to their 25 percent share of Medicaid-covered expenditures as non-Medicaid state contributions.

²⁸ See CMS, *State Operations Manual*, chapters 1 and 4 (noting that while facilities are surveyed simultaneously for multiple programs, costs are allocated equitably).

surveys. CMS regional offices also monitor states' use of federal funds provided for survey activities.

State performance reviews. CMS established state performance reviews in fiscal year 2001. Annually, the agency's regional offices use the reviews to determine whether states are meeting federal requirements—both statutory and nonstatutory—and to identify areas for improvement in state program management. The reviews assess states' performance across 18 standards, which generally focus on the timeliness and quality of surveys, complaint investigations, and enforcement actions. Since establishing the performance standards, CMS has continued to refine and expand their scope. For example, the standards originally focused on state nursing home survey activities, but now include ambulatory surgical centers, comprehensive outpatient rehabilitation facilities, end-stage renal dialysis facilities, home health agencies, hospices, hospitals, intermediate care facilities for the mentally retarded, and rural health clinics. However, only the survey frequency standards—whether states are completing surveys within statutory time frames or CMS-established survey priorities—encompass all 13 facility types surveyed by states. In fiscal year 2006, CMS began penalizing states that did not complete their entire tier 1 workload by reducing the states' Medicare funding allocation for the following year.

Federal monitoring surveys of nursing homes. Regional office staff conduct statutorily required federal monitoring surveys annually in at least 5 percent of state-surveyed Medicare and Medicaid nursing homes in each state. Federal monitoring surveys, which can be either comparative or observational, provide an indication of the quality of state nursing home surveys. For a comparative survey, federal surveyors conduct an independent survey of a nursing home recently surveyed by a state in order to compare the findings. When federal surveyors identify a deficiency not cited by state surveyors, they assess whether the deficiency existed at the time of the state survey and should have been cited by state surveyors. In prior work, we used the results of federal comparative surveys as a benchmark for identifying when state surveys have failed to cite a deficiency altogether or cited a deficiency at too low a level.²⁹ For observational surveys, federal surveyors accompany a state survey team to a nursing home to evaluate the team's on-site survey performance and

²⁹For an analysis of the results of federal monitoring surveys conducted from fiscal years 2002 through 2007, see GAO, *Nursing Homes: Federal Monitoring Surveys Demonstrate Continued Understatement of Serious Care Problems and CMS Oversight Weaknesses*, [GAO-08-517](#) (Washington, D.C.: May 9, 2008).

ability to document survey deficiencies. Observational surveys allow federal surveyors to provide more immediate feedback to state surveyors and to identify state surveyor training needs. In fiscal year 2007, 786 federal monitoring surveys were conducted, 170 of them comparative, 616 observational.

States' use of federal funds for survey activities. CMS regional offices are responsible for reviewing state spending. This oversight has two key aspects. First, regional office staff monitor states' Medicare spending during the fiscal year and states' adherence to CMS policies and guidelines. If states request supplemental Medicare funds, regional offices evaluate the states' requests and make recommendations to the CMS central office. Second, according to CMS's *State Operations Manual*, a state must allocate the costs of a survey to Medicare, Medicaid, and state licensure based on the extent to which each of these programs benefit from the survey. According to CMS central office officials, regional office staff are responsible for working with states to establish the amount of non-Medicaid state funds that states contribute to cover the costs associated with their derived benefit and their licensing requirements that differ from federal requirements.

Results in Brief

Federal funding for state surveys increased from fiscal years 2000 through 2002 but was nearly flat from fiscal years 2002 through 2007. In inflation-adjusted terms, funding fell 9 percent from fiscal years 2002 through 2007. CMS has made incremental adjustments to address both the recent funding trend and survey budget allocation weaknesses. CMS shifted Medicare funding from certain support contracts, such as the development of a new nursing home survey methodology, to increase funding for state surveys, providing an increase of about 1 percent on average in fiscal years 2006 and 2007. CMS also attempted to reduce states' survey workload by increasing the amount of time between surveys for facility types whose survey frequencies are not prescribed by statute and, at the same time, incorporating a risk-based system for prioritizing surveys of the most problematic facilities. About 13 percent of facilities had not been surveyed by states in 6 years or more as of September 30, 2007. In 2005, CMS developed a new budget analysis tool to identify and address funding inequities resulting from CMS's previous method for allocating Medicare funds for state survey activities based on past spending. Although CMS has used the tool to distribute annual funding increases according to states' survey workload, it has not used the tool to realign states' base-level funding with their workload. CMS also asked states to develop contingency plans to mitigate problems associated with the delayed

notification of their final Medicare budget allocations, which has occurred 6 months or more after the start of states' fiscal years.

Almost all states were unable to meet CMS survey priorities across tiers 1 through 3 in fiscal years 2006 and 2007, but pinpointing the cause is difficult because several factors such as workload, funding, staffing, and management may have affected states' ability to complete these priorities and the quality of the surveys conducted. It is difficult to distinguish the extent to which each factor had an impact. We found that states' required survey workload—the workload that states would have to complete to meet statutory and CMS survey frequency requirements—decreased 4 percent from fiscal years 2000 to 2007. This decrease was due to the decline in the number of nursing homes and intermediate care facilities for the mentally retarded, which are the most resource intensive facilities to survey. The declines in these two facility types offset the growth in the overall number and type of facilities subject to surveys. Nursing homes and intermediate care facilities for the mentally retarded (1) are surveyed on average every 12 months, while some other facilities are surveyed every 10 years as of fiscal year 2007, and (2) require more hours to survey compared to other facilities; together these two facility types accounted for 93 and 91 percent of states' required survey workload in fiscal years 2000 and 2007, respectively. The impact of changes in the number of state complaint investigations on state survey workload is unclear because CMS lacks reliable and consistent state data on complaints received and investigated. While data from fiscal years 2000 through 2007 show small increases in average survey hours for most facility types, it is difficult to determine whether the changes are due to new CMS directives and more stringent survey standards implemented since 2000 or other factors such as surveyor experience levels. Furthermore, we could not determine the extent to which funding has affected states' completion of surveys in tiers 1 through 3 because CMS and states disagree about whether funding is sufficient to complete surveys in these tiers and several states that spent more than their initial Medicare allocations still did not complete all such surveys. In addition, many states we contacted reported that an unstable workforce has affected their ability to meet CMS survey priorities in the past several years. In some cases, high surveyor attrition rates and state hiring freezes prevented 14 states we contacted from spending their entire Medicare funding allocations. States' completion of surveys in a given tier does not ensure that the surveys are thorough. For example, CMS found that 25 percent or more of some nursing home surveys in 7 states missed serious deficiencies. In one of these states, performance issues raised concerns about the management of survey activities.

CMS oversight of states' use of survey funds is limited because it relies on state-reported data, has inadequate information about non-Medicaid state funding, and does not require states to justify supplemental funding requests. To oversee how states spend federal funds, CMS regional offices now rely primarily on off-site reviews of state reports that document expenditures and workload. Regional office officials have expressed concern about whether state expenditures are accurately reported through CMS's Web-based, automated reporting system, and there have been instances where errors were discovered in states' expenditure reports well after their submission. Regarding states' non-Medicaid contributions to help fund survey activities, officials from the regional offices we spoke with told us that these rates have not been reviewed since they were established, even though federal survey and state licensure requirements may have changed over time. Furthermore, regional officials told us that they do not verify that states contributed funds in a manner consistent with their established contribution rates, noting limits on their authority to require submission of such data and states' refusal to provide it voluntarily. In addition, because states are not required to justify requests for supplemental Medicare funds, it is difficult for CMS to determine whether expenditures in excess of a state's initial Medicare allocation represent a state's non-Medicaid share of survey costs.

The evidence is mixed on whether federal funding has kept pace with the changing survey workload. The required survey workload decreased nationwide, but most states told us that survey frequencies of 6 to 10 years for many facilities could adversely affect beneficiaries. Moreover, it is often difficult to distinguish the overall impact of funding, staffing, and management on state workloads. We believe that these and other weaknesses in CMS's current funding approach will continue to frustrate its efforts to support and oversee state survey activities.

To address weaknesses in the current approach for overseeing facilities that participate in Medicare and Medicaid, we recommend that CMS undertake a broad reexamination of how survey activities are funded and conducted. In the shorter term, we also recommend that the CMS Administrator take nine actions to address concerns raised in this report, including (1) increasing the survey priority assigned to facilities that have not been surveyed in 6 years or more, (2) using available tools to better align states' baseline Medicare allocations with their workload, (3) identifying appropriate methodologies to help evaluate the efficiency and effectiveness of state survey activities, and (4) collecting information about current non-Medicaid state shares and the methodologies used to calculate them. We provided a draft of this report to HHS for comment. In

response, the Acting Administrator of CMS provided written comments in which the agency disagreed with elements of our survey workload analysis, but concurred with 9 of our 10 recommendations and partially concurred with the other recommendation. The Association of Health Facility Survey Agencies (AHFSA) also disagreed with elements of our survey workload analysis.³⁰

CMS Took Modest Steps to Address Recent Funding Trends and Manage Survey Funding Allocations

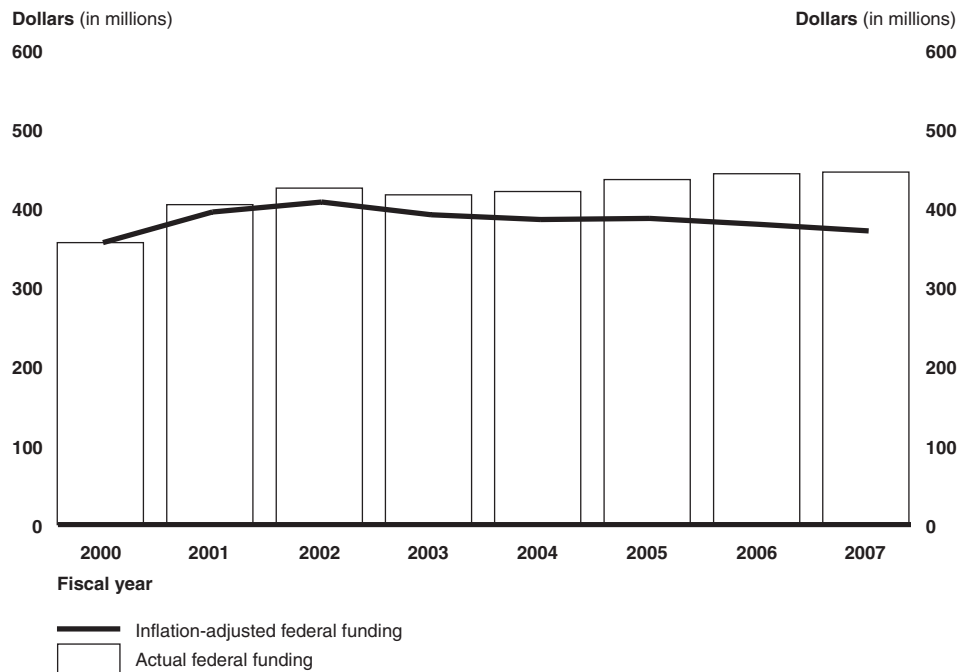
Federal funding for state surveys increased from fiscal years 2000 through 2002 but was nearly flat from fiscal years 2002 through 2007. In inflation-adjusted terms, funding fell 9 percent from fiscal years 2002 through 2007. CMS has taken incremental steps to address both the recent trend in funding levels and survey budget allocation weaknesses. CMS has placed a priority on funding state surveys at the expense of certain support contracts, such as the development of a new nursing home survey methodology. To ensure that states would have to conduct some surveys of every facility type each year, CMS distributed the survey requirements for several facility types across more than one tier, placing a higher priority on surveying the most problematic facilities. At the same time, it increased the average time between surveys for many facility types. Recognizing that its previous method for allocating Medicare funds for state survey activities resulted in over- and underfunding relative to state survey requirements, CMS developed a new budget analysis tool in 2005. However, use of the tool has been confined to making incremental adjustments, rather than baseline reallocations, to Medicare survey funding. In addition, the agency asked states to develop contingency plans to prepare for possible reductions in Medicare funding.

³⁰AHFSA represents survey agencies from all 51 states.

Federal Funding for Survey Activities Was Nearly Flat from Fiscal Years 2002 through 2007

Federal funding for state surveys increased from fiscal years 2000 through 2002 but was nearly flat from fiscal years 2002 through 2007. In inflation-adjusted terms, funding increased modestly by 4 percent over the entire 8 fiscal years, but fell 9 percent from fiscal years 2002 through 2007 (see app. III). In fiscal year 2008, Medicare funding for survey activities increased by about 7 percent after adjusting for inflation.³¹ Figure 1 compares overall federal funding for survey activities in actual and inflation-adjusted dollars for fiscal years 2000 through 2007.

Figure 1: Federal Medicare and Medicaid Funding for Survey Activities in Actual and Inflation-Adjusted Fiscal Year 2000 Dollars, Fiscal Years 2000 through 2007



Source: GAO analysis of CMS data.

Note: Fiscal year 2007 was the last year of complete data for total federal funding. Actual federal funding for survey activities increased from approximately \$356 million in fiscal year 2000 to almost \$444 million in fiscal year 2007, which is equivalent to a change from \$356 million to \$371 million when adjusted for inflation.

³¹Overall federal funding for fiscal year 2008 survey activities will not be known until the end of that fiscal year when final Medicaid expenditures become available.

For about 3 months in calendar year 2007, CMS charged and retained fees for revisits from Medicare facilities.³² In fiscal year 2007, Congress required CMS to charge user fees for revisit surveys and to use those fees to cover the costs of these surveys.³³ That authority was extended through part of fiscal year 2008 through a series of continuing resolutions.³⁴ According to CMS, the agency sought this authority to encourage Congress to fund requested increases in the Medicare survey budget, breaking what they perceived to be a cycle of inadequate funding for survey activities.³⁵ The agency billed facilities about \$8 million during the 3 months that the revisit user fee program was in effect. Although this authority was requested in the President's Budget for fiscal year 2008, Congress did not provide it.³⁶

³²In general, agencies have authority to charge fees under the Independent Offices Appropriation Act unless prohibited by some other law, 31 U.S.C. § 9701, but may not retain them unless they have specific statutory authority to do so. See 31 U.S.C. § 3302. However, the general authority is unavailable to CMS with respect to its survey activities because Congress has prohibited CMS from imposing fees for survey activities. 42 U.S.C. § 1395aa(e).

³³Revised Continuing Appropriations Resolution, 2007, Pub. L. No. 110-5, § 2, 121 Stat. 8, 33. CMS published the final rule for the revisit user fee program in the *Federal Register* on September 19, 2007, and the program began on that day. Establishment of Revisit User Fee Program for Medicare Survey and Certification Activities, 72 Fed. Reg. 53,628 (Sept. 19, 2007) (codified at 42 C.F.R. § 488.30).

³⁴Fees were collected from September 19, 2007 (the date CMS published the final rule for the revisit user fee program in the *Federal Register*) through December 25, 2007. A series of continuing resolutions extended CMS's authority to charge and retain fees into fiscal year 2008 until the Consolidated Appropriations Act, 2008, which did not renew the authority, became law on December 26, 2007. See Pub. L. No. 110-92, §101, 121 Stat. 989, 989 (2007); Pub. L. No. 110-116, div. B, § 101, 121 Stat. 1295, 1341 (2007); Pub. L. No. 110-137, 121 Stat. 1454 (2007); Pub. L. No. 110-149, 121 Stat. 1819 (2007). CMS published a series of *Federal Register* notices to correspond with its authority to conduct the program under the continuing resolutions. See 72 Fed. Reg. 61,540 (Oct. 31, 2007); 72 Fed. Reg. 71,579 (Dec. 18, 2007); 73 Fed. Reg. 3405 (Jan. 18, 2008); 73 Fed. Reg. 11,043 (Feb. 29, 2008).

³⁵In seeking this authority, CMS requested that fees reduce rather than supplement funding from the Medicare Trust Funds. As enacted, the authority did not limit the fees to a specified amount or provide for such a reduction from the Medicare Trust Funds.

³⁶Consolidated Appropriations Act, 2008, Pub. L. No. 110-161, div. G, tit. 2, 121 Stat. 1844, 2177-78 (2007).

CMS Took Modest Steps to Address Budgetary Stress from Fiscal Years 2002 through 2007

In response to a decline in inflation-adjusted funding since fiscal year 2002, CMS modestly increased the amount of Medicare funds targeted for state surveys in fiscal years 2005 through 2007 by tapping into its support contract funds. For example, in fiscal year 2007, CMS cut Medicare funding for support contracts by about 17 percent (\$2.7 million) and correspondingly increased states' Medicare allocation for conducting surveys by 1.3 percent, ranging from about \$9,000 to about \$368,000 a state (see table 3). A CMS official also told us that the agency has decreased funding for and thus slowed the refinement and implementation of the new nursing home Quality Indicator Survey (QIS)—a project funded through a support contract initiated about 10-years ago that is intended to improve the consistency and efficiency of state surveys and provide a more reliable assessment of quality.³⁷ CMS had intended to significantly expand implementation from the 5 pilot states, but has only added 3 of the 13 states interested in transitioning to the QIS. As of May 2008, CMS projected that the QIS would not be fully implemented nationally until 2014, at an estimated cost of about \$20 million. According to CMS officials, further reductions in support contracts would adversely affect the activities funded through the contracts.

Table 3: Changes in Medicare Support Contract Funding and Funding for State Surveys

Fiscal year	Percentage change in support contract funding (dollar amount)	Percentage change in average state funding for surveys (minimum and maximum funding increases per state)
2005	-8.5 (\$1,722,000)	3.8 (\$6,000 to \$1,304,000)
2006	-16.1 (\$2,987,000)	1.1 (\$7,000 to \$315,000)
2007	-17.2 (\$2,684,000)	1.3 (\$9,000 to \$368,000)

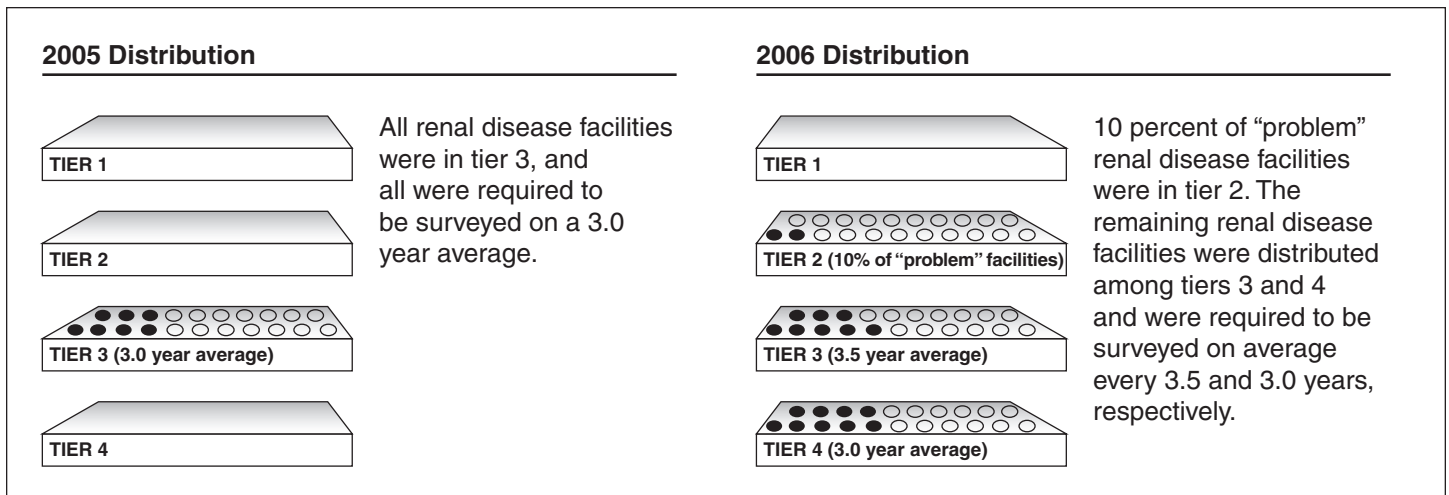
Source: CMS.

In fiscal year 2006, CMS adopted a risk-based approach for state survey requirements in response to declining inflation-adjusted funding since fiscal year 2002. This approach entailed distributing the survey requirements for several facility types across more than one tier, thus ensuring that states would have to conduct some surveys of every facility

³⁷The QIS is a two-stage, data-driven survey process intended to systematically target potential problems at nursing homes by allowing surveyors to use an expanded sample of residents and structured interviews. In 2007, CMS concluded a demonstration of the QIS survey methodology.

type each year. First, CMS required states to survey a targeted sample of the most problematic facilities as a tier 2 priority for many facility types. States select 5 percent or 10 percent of facilities, depending on the type, from a CMS list that identifies those most at risk of providing poor care. In addition, CMS moved the previous tier 3 requirement for many facility types to tier 4 and increased the average time between surveys for tier 3. By doing this, CMS effectively increased the average time between surveys in tier 3—for example, from every 6 years to every 8 years—for nine facility types whose survey frequencies are not set by statute (see app. II). For example, survey requirements for end-stage renal disease facilities—a tier 3 priority in fiscal year 2005—were spread across tiers 2, 3, and 4 in fiscal year 2006. States were required to survey a 10 percent sample of these facilities selected for tier 2, while surveying facilities for tiers 3 and 4 on an average of 3.5 and 3.0 years, respectively (see fig. 2). The 3-year average for tier 4 reflects CMS’s policy for end-stage renal disease facility surveys, but CMS acknowledges that Medicare funding may not be sufficient for most states to accomplish tier 4 survey priorities.

Figure 2: Average Survey Frequencies for End-Stage Renal Disease Facilities by CMS Workload Prioritization Tiers, Fiscal Years 2005 and 2006



Source: GAO.

Note: The filled dots represent the proportion of end-stage renal disease facilities surveyed in each tier in each year; the change in the volume of dots between 2005 and 2006 does not represent a change in the number of facilities between each year.

In fiscal year 2007, CMS further increased the average survey frequency in tier 3 for five facility types from 8 years to 10 years and for one facility type from 3.5 years to 4 years.³⁸ Despite this, we found that from fiscal years 2000 to 2007 the increased average survey frequency had almost no impact on states' required survey workload. Given the fiscal year 2008 increase in Medicare funding, CMS decreased the time between surveys for many facility types, returning them to approximately fiscal year 2000 levels (see app. II).³⁹

Despite CMS's risk-based approach, some state-surveyed facilities have not been surveyed for many years.⁴⁰ About 2,700 facilities (13 percent) whose survey frequencies are established by CMS had not been surveyed in 6 years or more as of September 30, 2007 (see table 4); about 900 (4 percent) had not been surveyed in 10 years or more.⁴¹ Officials from both CMS and most of the states we contacted told us that the time between surveys for facilities without statutory survey frequencies was too long, which can increase the risk for quality problems. For example, officials from several states told us that they cite deficiencies more often, or the deficiencies are more serious, at facilities that are surveyed infrequently. Officials from one state said that facility administrators might become complacent about meeting federal quality standards during the lengthy periods between surveys. Officials from another state told us that, in 2006, surveyors of hospices in their state cited serious deficiencies on four out of eight surveys. Many state officials said that the survey frequency for all facilities that are not set by statute should be every 2 to 3 years.

³⁸Fourteen of the 28 states we contacted told us that they survey some providers more frequently than CMS requires. For example, Florida, Pennsylvania, and Washington survey unaccredited hospitals every year, every 2 years, or every 1-1/2 years, respectively.

³⁹Starting in fiscal year 2008, CMS switched from an average to a maximum survey interval for facilities in tier 3 in order to (1) increase its ability to hold states accountable, (2) increase the clarity of the expectation, and (3) increase the integrity of the measure. However, tier 4 survey frequencies remained an average frequency of all facilities in that tier.

⁴⁰Our analysis excluded accredited facilities.

⁴¹Approximately 74 percent of facilities that had not been surveyed within fiscal year 2007 survey frequencies were in 11 states: Alabama, California, Colorado, Illinois, Louisiana, Maryland, Michigan, New York, North Carolina, Ohio, and Pennsylvania.

Table 4: Facilities with Survey Frequencies Established by CMS That Have Not Been Surveyed in 6 Years or More, as of September 30, 2007

Facility type	Facilities that have not been surveyed in 6 years or more	
	Number	Percentage
Non-accredited ambulatory surgical center	783	20%
Outpatient physical therapy provider	531	18%
Rural health clinic	511	14%
Non-accredited hospice	292	11%
End-stage renal disease facility	260	5%
Portable X-ray service	142	25%
Non-accredited hospital	84	5%
Comprehensive outpatient rehabilitation facility	67	12%
Total	2,670	13%

Source: GAO analysis of OSCAR data.

CMS's Attempts to Increase the Effectiveness of the Survey Budget Allocation Process Have Had a Limited Impact

Budget Analysis Tool

CMS's attempts to make the survey budget allocation process more effective have had a limited impact. In fiscal year 2005, it began using a budget analysis tool to more equitably distribute funding to states. It also asked states to develop contingency plans to deal with the uncertainty about state funding due to the timing of the Medicare budget allocation process.

The budget analysis tool was designed to address funding inequities resulting from CMS's previous method for allocating Medicare funds for state survey activities, but its impact has been limited. Previously, CMS determined states' allocations based on their past spending, but this method did not guarantee that funding levels accurately reflected state workloads—some states received too much funding given their survey workloads, others too little. For example, regional office staff told us that a state hiring freeze in the 1990s caused severe understaffing for one state in their region. One year, this state spent significantly less than its Medicare allocation because it was unable to hire staff. Consequently, the following year this state's Medicare funding increases reflected the previous year's low level of expenditures and the relatively low level of Medicare funding has been carried forward every year. CMS officials chose not to use the tool to recalculate states' base allocations to avoid

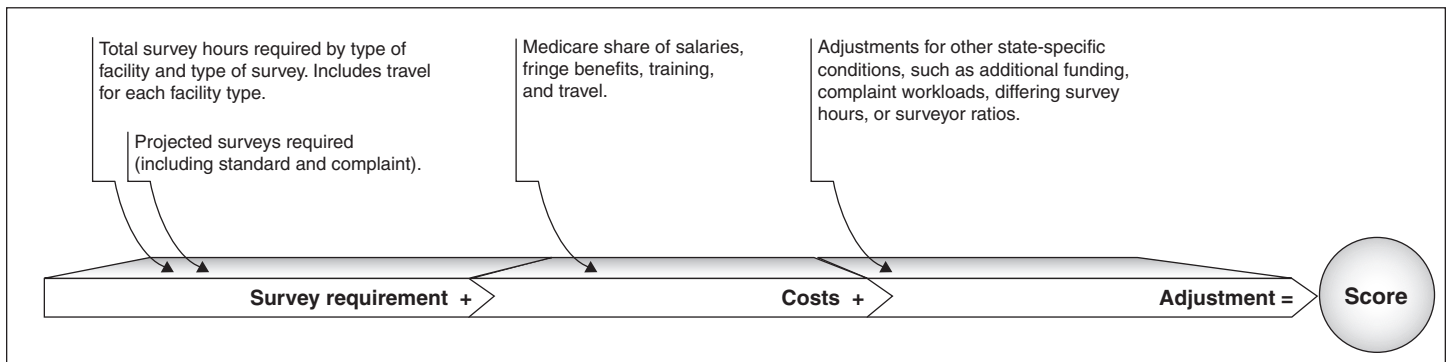
shifts that could result in layoffs of trained staff. CMS officials anticipated that over time the use of the budget analysis tool would incrementally align state funding with workload.⁴²

The budget analysis tool allows CMS to measure state survey workload against funding and compare the match of workload to funding across states. It uses both state-specific and national data to measure state survey requirements, such as hours needed to perform surveys, and states' costs for conducting survey activities, such as salaries, as well as fringe benefits for those staff, training, and travel. While state-specific data are used to calculate workloads for nursing homes, national averages are used for other facilities because they are surveyed so infrequently. The tool makes final adjustments based on regional office analysis and other factors. The tool then scores each state from 1 (less well-funded, relative to other states) to 5 (better funded) given the state's workload (see fig. 3). In 2005, 10 states scored 1 and 15 states scored 4 or 5. In 2008, 7 states had a score of 1 while 14 had a score of 4 or 5.

An agency official acknowledged that there are limitations in the tool's effectiveness. First, state scores do not account for state enforcement activity or the fixed costs associated with administering survey activities. Second, CMS officials told us that they did not know how long an efficient survey should take and could not assess whether the considerable interstate variation in the length of surveys was appropriate. Third, state-specific data are limited for most facility types other than nursing homes because they are surveyed less frequently.

⁴²The budget allocation process will gradually reflect changes that affect states' survey expenditures. For example, officials from one state told us that, in 2006, the state experienced a dramatic increase in its travel reimbursement; however, these increased costs were not reflected immediately in the state's Medicare funding since the budget allocation process still largely considers states' historical expenditures.

Figure 3: Budget Analysis Tool, Including Component Parts



Source: GAO.

CMS has used the budget analysis tool five times: (1) twice to distribute annual increases in Medicare funds to states (after allocating a small across-the-board inflation increase), and (2) three times to redistribute Medicare funds at the end of the fiscal year to states that spent more than their initial allocations by using state funds and had requested supplemental funding. In fiscal year 2005, CMS used the tool to distribute a 3 percent increase in survey funding, which translated into a 0.5 percent to 9.5 percent increase depending on the state. In fiscal year 2008, average increases to states ranged from about 10 percent for states which scored 1 to about 6.5 percent for states which scored 5. In fiscal years 2005 through 2007, CMS used the tool to redistribute year-end supplemental funding to states, but the amount to be redistributed has shrunk in recent years. For example, CMS had about \$6 million available to redistribute in fiscal year 2005 but only about \$2.5 million in fiscal year 2007.

State Contingency Budget Plans

To help address uncertainty about federal Medicare funding levels, CMS asked states to develop a baseline budget and contingency plans for a specified reduction or increase to the baseline for fiscal years 2007 and 2008.⁴³ In general, CMS communicates state-projected allocations in August, before the beginning of the next federal fiscal year. These

⁴³In fiscal year 2007, CMS asked states to develop contingency plans to accommodate a 0.5 percent reduction and an increase ranging from 0.5 percent to 3.5 percent, depending on the state's budget analysis tool score. For fiscal year 2008 funding, CMS asked for contingency plans to accommodate a reduction from 0.5 percent to 2.5 percent and an increase ranging from 1.5 to 2.5 percent, again depending on the state's budget analysis tool score. After the fiscal year 2007 and 2008 appropriations were enacted, CMS communicated states' actual Medicare allocations.

projected allocations may be more or less than the final allocation and, for the past several years, CMS's budget for state survey activities has not been finalized until 6 to 8 months later. CMS acknowledged the uncertainty that resulted from states not knowing their final Medicare allocations until well into the state fiscal year, which for most states begins on July 1.

Regional office and state officials identified several problems that can result from finalizing states' Medicare allocations late in the state fiscal year. First, officials from one regional office told us that states had to conduct their survey work cautiously until they received their final Medicare allocations, which could be less than initially projected. In some cases, the uncertainty may cause states to defer some of their surveys until the end of the fiscal year, potentially causing them to spend less than their Medicare allocations. Second, officials from one state told us that if their Medicare allocation was less than initially projected, they would have to cut staff or other direct costs such as travel—all essential to completing their survey workload. Third, officials from another state said that the lag in receiving their final Medicare allocation further delayed hiring new staff.

Almost All States Were Unable to Complete Their Survey Workload, and Pinpointing the Cause Is Difficult

Only one state, Arkansas, was able to complete all surveys in tiers 1 through 3 in fiscal year 2006, but pinpointing the cause is difficult because (1) several factors such as workload, funding, staffing, and management could have had an impact and (2) distinguishing the extent to which each factor contributed to state completion rates and the quality of each states' surveys is challenging. Overall, we found that states' required survey workload—the workload that states would have to complete to meet statutory and CMS survey frequency requirements—decreased 4 percent from fiscal years 2000 to 2007. This decrease was due to a decline in the number of the most frequently surveyed facilities that also require more time to survey compared to other facilities. This decline offset the workload increase from the overall growth in the number and type of other facilities subject to surveys over the same time period. It is unclear how states' complaint investigation workload changed over this same time period because CMS lacks reliable and consistent state data on complaints received and investigated. According to CMS, the agency adjusts the survey priorities in tiers 1 through 3 so that the workload is feasible given Medicare funding levels, but the states we contacted disagree. However, some of the states we contacted that spent significantly more than their initial Medicare allocations still did not complete all surveys in those tiers. Sixteen of the 28 states we contacted were unable to spend their entire

Medicare allocations, most indicating that this was due to high surveyor attrition rates and hiring freezes. Though many states believe that noncompetitive surveyor salaries contribute to attrition, states, not CMS, establish those salaries. In two states, CMS concluded that poor management of the survey process had compromised the quality of state surveys, but acknowledged that in one of the states staffing levels, salaries, and other issues may have been a contributing factor.

Almost All States Were Unable to Complete CMS's Survey Priorities Despite Decreases in the Required Survey Workload

CMS state performance reviews for fiscal years 2006 and 2007 found that few states were able to complete or nearly complete all surveys in tiers 1 through 3, despite decreases in the required survey workload from fiscal years 2000 to 2007.⁴⁴ However, the impact of complaint investigations and revisits on state workloads during this time period is unclear because the data were not complete or reliable.

Completion of CMS Survey Priorities

Only one state, Arkansas, was able to complete its surveys in all three tiers in fiscal year 2006.⁴⁵ Seventeen states did not complete their tier 1 surveys in fiscal year 2006 and, as a result, were assessed deductions totaling \$298,200 from their fiscal year 2007 Medicare survey allocations (see table 5).⁴⁶ Thirty-five states were unable to complete their tier 2 surveys and 46 states were unable to complete their tier 3 surveys. Some states narrowly missed completing surveys in one or more tiers, while others missed completion by a wide margin. For example, in fiscal year 2006 one state completed 99.9 percent of the surveys of intermediate care facilities for the mentally retarded, while another state completed only 33 percent of such surveys, but CMS rated both states as not meeting the survey workload.⁴⁷ Counting the few states that narrowly missed the standards as

⁴⁴In state performance reviews, CMS only examines states' accomplishment of the agency's workload priorities in tiers 1 through 3 because CMS believes funding is not sufficient for states to complete tier 4 priorities.

⁴⁵Two other states completed almost all of their workload in tiers 1 through 3. Pennsylvania completed 99.6 percent of home health agency surveys and Tennessee completed 99 percent of surveys for home health agencies and immediate care facilities for the mentally retarded.

⁴⁶The nationwide completion rates for nursing home (at least every 15 months) and home health agency (every 3 years) surveys have improved significantly since 2000 when states only accomplished about 96 percent and 89 percent of such surveys, respectively. In 2006 and 2007, the nationwide completion rates were 99.9 percent and 99.7 percent, respectively.

⁴⁷The state that completed almost all of these surveys had over 1,000 intermediate care facilities for the mentally retarded.

passing had little impact on the results presented in table 5. These results were similar in fiscal year 2007—25 states were unable to complete their tier 1 surveys, 34 did not complete tier 2 surveys, and 41 did not complete tier 3 surveys. CMS officials believe that recent Medicare funding levels have been sufficient for states to complete surveys in tiers 1 through 3.

Table 5: Number of States That Completed Required Surveys by Tier as Reported by CMS, Fiscal Year 2006

Tier	Number of states that completed requirement	Number of states that did not complete requirement
1	34	17
2	16	35
3	5	46

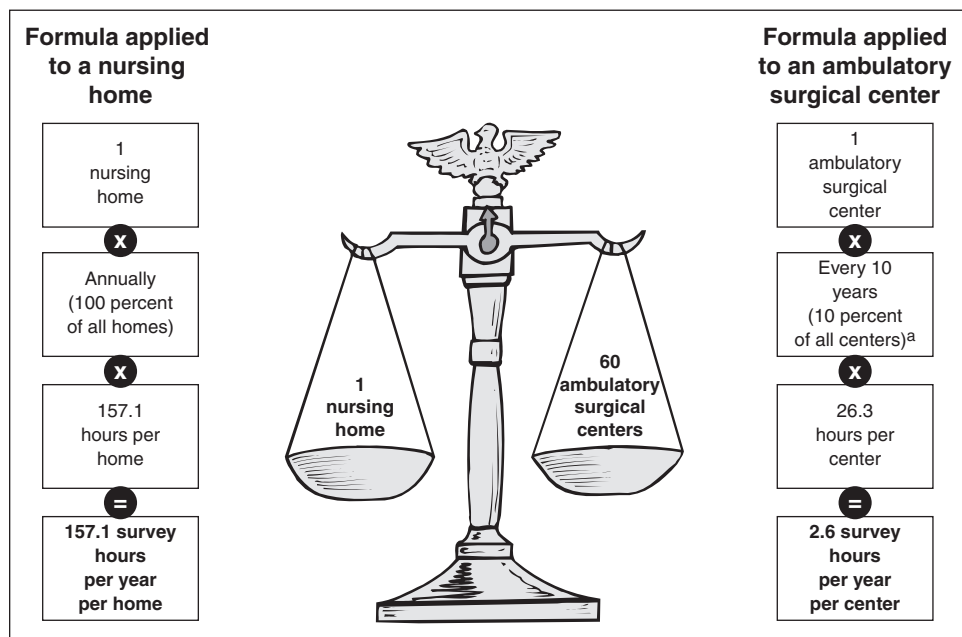
Source: CMS.

Decline in Required Survey Workload

States' required survey workload—the workload that states would have to complete to meet statutory and CMS survey frequency requirements—decreased nationally from fiscal year 2000 to fiscal year 2007, even though the number and type of facilities subject to surveys during that period increased. The decrease in the required survey workload was due primarily to the decline of more than 1,100 nursing homes and 300 intermediate care facilities for the mentally retarded (see app. IV). Declines in these two facility types offset overall increases in other facilities subject to surveys because nursing homes and intermediate care facilities for the mentally retarded are comparatively the most resource-intensive facilities to survey: (1) statute dictates that nursing homes and intermediate care facilities for the mentally retarded must be surveyed approximately every 12 months, and (2) their surveys take longer than most other facilities to complete. For example, even though the number of ambulatory surgical centers increased by 31 percent from fiscal year 2000 to fiscal year 2007, the increase had a small impact on the required survey workload because on average ambulatory surgical centers require 26 hours to survey and, as of fiscal year 2007, only had to be surveyed once every 10 years to meet tier 3 workload priorities; in contrast, nursing homes take 157 hours to survey and their surveys are tier 1 workload priorities that must occur an average of every 12 months. After factoring in both average survey hours and required frequencies, 1 less nursing home can offset the workload increase of 60 new ambulatory surgical centers (see fig. 4). Surveys of nursing homes and intermediate care facilities for the mentally retarded together accounted for about 93 percent of states' required survey workload in fiscal year 2000 and 91 percent of states'

required survey workload in fiscal year 2007; all other surveyed facilities accounted for less than 10 percent of the workload in both years.⁴⁸ When all facilities are considered, the required survey workload decreased by about 4 percent (see fig. 5).⁴⁹ Almost all of the decrease was due to the decline in nursing homes and intermediate care facilities for the mentally retarded; the increase in the interval between surveys had a negligible impact.

Figure 4: Formula to Estimate Required Survey Workload as Applied to Nursing Homes and Ambulatory Surgical Centers as of Fiscal Year 2007



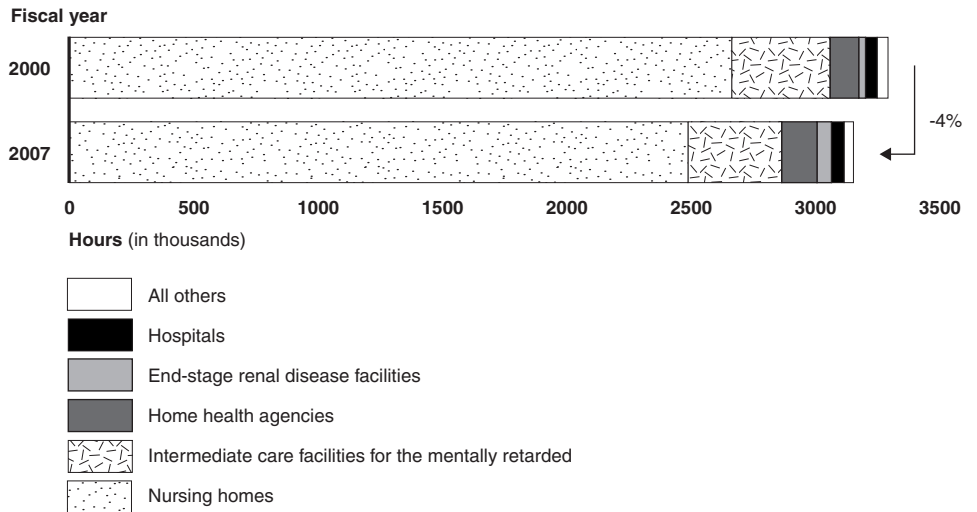
Source: GAO (analysis), Art Explosion (clip art).

^aOn average, 10 percent of ambulatory surgical centers are surveyed annually.

⁴⁸The impact on the required survey workload of facilities inspected by accrediting organizations was smaller than the number of facilities might suggest. Between December 2000 and December 2007, the number of facilities inspected by accrediting organizations increased by 39 percent from 5,399 to 7,488. Even though the increase is significant, CMS only requires that between 1 percent and 5 percent of these accredited facilities receive state validation surveys each year.

⁴⁹We also examined the required survey workload by state (see app. V).

Figure 5: Decline in Required Survey Workload (the Completion of Surveys within the Time frames for which CMS Holds States Accountable), Based on the Number of Facilities and Average Survey Hours, December 2000 to December 2007



Source: GAO analysis of CMS data.

Note: In 2000, nursing homes comprised 80 percent of the required survey workload, intermediate care facilities for the mentally retarded were 12 percent, home health agencies were about 3 percent, end-stage renal disease facilities and hospitals were about 1 percent each, and all other categories were less than 1 percent. In 2007, nursing homes were 79 percent, intermediate care facilities for the mentally retarded remained 12 percent, home health agencies were about 4 percent, end-stage renal disease facilities were about 2 percent, hospitals were about 2 percent, and all other categories were less than 1 percent.

The disproportionate impact of decreases in nursing homes and intermediate care facilities for the mentally retarded on states' required survey workload is illustrated by Washington. From fiscal year 2000 to fiscal year 2007, the number of facilities subject to surveys in Washington increased by about 16 percent due largely to growth in ambulatory surgical centers, end-stage renal dialysis centers, and rural health centers. In fiscal year 2007, these facility types were subject to surveys on average every 10, 4, and 10 years, respectively. During the same period, however, Washington experienced decreases in the numbers of nursing homes and intermediate care facilities for the mentally retarded, which, on average, are surveyed every 12 months. As a result, the number of surveys that Washington was expected to conduct each year decreased about 9 percent; when average survey hours are taken into account, the state's required survey workload decreased by 11 percent. Eleven states—Alabama, Alaska, Delaware, Florida, Georgia, Mississippi, New Jersey, North Carolina, Texas, Utah, and Virginia—experienced increases in their

Workload Impact of
Complaints, Survey Process
Improvements, and Revisits

required survey workload, ranging from less than 1 percent to about 8 percent (see app. V).

In addition to changes in the number and type of facilities subject to surveys, two other survey activities as well as survey process improvements could have affected states' overall workload, but the results for complaints and revisits were unclear because the data were not available or reliable.⁵⁰ It is difficult to discern from the data whether survey process improvements contributed to the small increases from fiscal years 2000 to 2007 in average survey hours for most facility types.

- **Complaint investigations.** Although complaint investigations represent a significant portion of state workload, CMS officials told us that the agency lacks complete and reliable data on complaints received and investigated.⁵¹ CMS implemented a new complaint database in 2004 but officials told us that the data are not reported consistently.⁵² First, a few states either do not report complaints in the CMS database or investigate complaints under state licensure, thus underreporting the number of complaints in the database. Second, states may not be consistently reporting complaints. According to CMS, the agency instructs states to differentiate between facility-reported incidents, which they can choose to investigate as complaints, and complaints received from residents, family members, or others. According to CMS, however, some states report few if any facility-reported incidents. Third, CMS believes that some states may be overestimating the number of complaints by reporting complaints received and investigated during standard surveys in the CMS complaints database. According to CMS, about 15 percent of complaints are investigated during standard surveys.

Although the changes in the complaint workload are difficult to quantify, both CMS and state officials told us that resource constraints have hampered complaint investigations. For example, according to both CMS and state officials, states may be bundling complaints—waiting until they

⁵⁰Revisits take place when state surveyors identify serious deficiencies that require additional on-site visits to ensure that the deficiencies have been corrected.

⁵¹For example, the President's fiscal year 2007 budget request estimated that the number of complaint investigations were almost double the number of state surveys.

⁵²In October 1999, CMS instructed states to investigate nursing home complaints alleging actual harm within 10 working days. A primary objective of survey funding increases in fiscal years 1999 and 2000 was to enable states to hire additional nursing home surveyors, particularly to perform complaint surveys.

receive two to three complaints about a particular facility and then investigating them all at the same time—resulting in less timely complaint investigations. One state now sends in one surveyor to investigate complaints rather than two or three, which had been a more typical team size. Officials from a different state expressed concern that complaint bundling may affect the adequacy of their investigations. State officials stressed that the unpredictable nature of complaint investigations can be disruptive to scheduling and completing standard and validation surveys.

State officials told us that CMS does not adequately fund complaint investigations and that CMS expects states to use their own funds. According to CMS officials, the amount identified for such investigations in the fiscal year 2008 President's budget request does not fully fund all anticipated complaint investigations. We believe, however, that it is appropriate for states to cover the additional costs of completing complaint investigations within state time frames that are more stringent than federal requirements. For example, both California and Pennsylvania require all investigations to be initiated within 10 days, while CMS requires such rapid investigations only for complaints alleging immediate jeopardy or actual harm. In contrast, Florida requires all complaints to be investigated within 90 days. We believe that it is difficult to determine the appropriate federal funding level for complaint investigations without a complete estimate of the complaint workload.

- **Revisits.** CMS does not have reliable and complete data on revisits from fiscal years 2000 to 2004 due to changes in how revisit survey activities were reported across states. As a result, it is not possible to fully account for the impact of revisits on states' overall survey workload. However, CMS data for fiscal years 2005 to 2007 show that the revisit workload declined by 4 percent. Revisits for standard surveys accounted for approximately 8 percent of states' survey workload in fiscal year 2007 and nursing homes and intermediate care facilities for the mentally retarded constituted about 85 percent of states' revisit workload in 2007. We believe that the decline in revisits for fiscal years 2005 to 2007 is consistent with states' overall decline in survey workload since fiscal year 2000.
- **Survey process improvements.** To improve the quality of state surveys, CMS has implemented new directives and more stringent standards for surveys, which CMS believes have increased states' survey workload. For example, CMS added new survey requirements for hospices and end-stage renal disease facilities and required states to include in their surveys home health and outpatient physical therapy locations (branches and extensions, respectively) that are under the supervision of a licensed

facility. According to one state we interviewed, new requirements (1) increase the time required to conduct surveys and (2) require additional surveyor training, which decreases productivity and is not reflected in recorded survey hours. Although new requirements that result in additional time to conduct surveys should be reflected in the survey hours that states report, CMS expressed doubt that survey hours were actually increasing as a result of these initiatives because it believes that states lack adequate resources to carry them out. Data for fiscal years 2000 to 2007 show small increases in average survey hours for most facility types; however, it is difficult to determine whether these changes are due to the new requirements or to factors such as surveyor experience levels.

Multiple Factors May Affect States' Ability to Complete Survey Workloads

Several other factors—funding, staffing, and management of the survey process—may have an impact on states' ability to complete survey workloads and these factors also influence the quality of surveys. These factors are often interrelated and can play out differently in each state. States disagree with CMS's position that there is sufficient funding to complete the workload in tiers 1 through 3, primarily because of workforce instability due to noncompetitive salaries. However, states, not CMS, establish these salaries and manage the workforce and the survey process.

Funding Sufficiency

CMS established the tiered survey priorities to ensure that Medicare funding was sufficient for states to complete surveys in tiers 1 through 3.⁵³ While most of the states we contacted believe that CMS's expectations are unreasonable, the data suggest the influence of factors other than the federal Medicare allocation. For example, 16 of the 28 states we contacted spent more than their fiscal year 2006 initial Medicare allocations, but none were able to complete all required surveys in these three tiers. Seven of these states were unable to complete even their tier 1 requirements—those that are statutorily mandated. For example, Missouri spent more than its fiscal year 2006 initial Medicare allocation and was able to complete all of its surveys in tiers 2 and 3 but failed to complete its entire tier 1 workload. On the other hand, 16 of the states we contacted spent less than their Medicare funding for fiscal years 2000 through 2006, 11 of these states spent less than their fiscal year 2006 allocations. For some of these states, the ability to spend Medicare allocations—not the Medicare funding level itself—affected their ability to complete the required surveys.

⁵³The Medicare funding penalties that CMS assesses when states fail to complete all tier 1 surveys underscore that at a minimum a state should be able to complete all such surveys.

Officials from 23 of the states we contacted told us that an additional \$35 million in cumulative Medicare funding was needed, primarily to increase surveyor salary levels so that states could fill staff vacancies and offer incentives to retain current staff, issues that they believe have significantly inhibited their ability to complete required surveys.⁵⁴ Conversely, officials from 4 states told us they did not need any additional Medicare funding.⁵⁵

Workforce Instability

Officials from AHFSA and many of the 28 states we contacted told us that an unstable workforce had affected their ability to meet CMS survey priorities over the past several years. The workforce instability arises mostly from noncompetitive salaries, which result in the hiring of less qualified candidates, and hiring freezes.⁵⁶ Salary levels, minimum qualifications, and decisions about when to hire or not hire surveyors are the result of state personnel policies that affect surveyor positions as well as positions for other state employees.

According to AHFSA and state officials, staff retention issues among states can be attributed primarily to noncompetitive salaries for RNs—the profession that comprises the largest proportion of surveyors nationally. In fiscal year 2006, the surveyor attrition rate among the 28 states we contacted ranged from 0 percent to about 46 percent, and 17 of these states reported attrition rates of 10 percent or higher. Officials from one state told us that the starting salary for their RN surveyors ranged from \$30,000 to \$35,000 and that trained RNs typically leave surveyor positions after a few years to seek jobs in the private sector for higher salaries. The average salary for RN surveyors in the 28 states we contacted was about \$59,000 in fiscal year 2006 and ranged from about \$37,000 to about \$88,000.⁵⁷ More recently, some states have been able to increase surveyor salaries from previous levels to compete with the private sector. For instance, in one state, the salaries of experienced surveyors increased by

⁵⁴In fiscal year 2008, Medicare survey and certification funding increased approximately \$23 million.

⁵⁵One state did not respond to this question.

⁵⁶We first reported on this issue in 2003. See GAO, *Nursing Home Quality: Prevalence of Serious Problems, While Declining, Reinforces Importance of Enhanced Oversight*, [GAO-03-561](#) (Washington, D.C.: July 15, 2003).

⁵⁷This salary range reflects variation across states in experience and education levels for RN surveyors. For example Washington only hires RNs with master's degrees and 10 years of experience, while other states hire RNs with no experience.

about 28 percent in fiscal year 2007. However, officials from 13 states are concerned that any increase in surveyor salaries may not be sustainable in the long-term without increases in state Medicare allocations. Without an increase, these states indicate that they may have to lay off staff, which would adversely affect their ability to complete the survey workload.

According to AHFSA officials, states have hired applicants that are less qualified for surveyor positions due to noncompetitive surveyor salaries. They told us that some states formerly hired RN surveyors with bachelor's degrees, but given current salary levels, these positions may only be attractive to licensed practical nurses with 2-year rather than 4-year degrees. States are also hiring nurses with less nursing experience to fill the positions. Of the 28 states we contacted, 6 states offered surveyor positions to applicants with no prior experience. AHFSA officials believe that inexperienced surveyors tend to be less productive and require increased supervision and oversight.

Hiring freezes have also affected states' abilities to manage their survey workloads. During the past few years, some states temporarily suspended the hiring of state employees due to state budget deficits. Consequently, states had to suspend hiring of surveyors, even though they may have had sufficient federal funding to support the additional staff. Of the 28 states we contacted, 16 states spent less than their Medicare budget allocations from fiscal years 2000 through 2006 and 14 of them identified hiring freezes or vacancies as the primary reason. With consistently high turnover rates among these states' surveyors, the hiring freezes prevented states from filling vacant positions.

Survey Process Management

Given workforce instability, states told us that they have adjusted how they manage surveys to meet CMS priorities. Some states adjust the size of a survey team depending on the availability of staff. Of the 28 states we contacted, officials from 20 states indicated that they reduced the survey team size or restricted the time a surveyor is allowed to spend in a facility in fiscal year 2006. Officials from one of these states explained that, in the past, a survey team may have consisted of four surveyors plus a specialist, but now a survey team only consists of three surveyors. As noted earlier, they also told us that a state may send one surveyor to investigate several complaints whereas previously, multiple surveyors were sent to investigate complaints. Additionally, a state may limit or restrict the time a surveyor is allowed to spend in a facility to ensure that other facilities are surveyed and the state meets CMS performance measures. As a result, officials from 11 states told us that surveyors do not have enough time to conduct thorough surveys.

Quality of Surveys

Although states may complete surveys in a given tier, this does not ensure that the surveys are thorough. CMS's 2006 state performance review indicated that Missouri, Oklahoma, New Mexico, South Carolina, South Dakota, Tennessee, and Wyoming completed all of their nursing home surveys within the statutorily required time frames. But, as we previously reported, more than 25 percent of federal comparative surveys conducted in these states from fiscal years 2002 through 2007 found that state surveyors had missed serious deficiencies.⁵⁸ For example, South Carolina missed at least one serious deficiency on 6 of the 18 comparative surveys during those 6 fiscal years, with an overall total of 19 missed deficiencies that caused harm or placed residents in immediate jeopardy.

In one of these states, CMS told us that performance issues raised concerns about the management of survey activities. For example, 26 percent of federal comparative surveys conducted in Tennessee from fiscal years 2002 through 2007 found that state surveyors had missed serious deficiencies. Moreover, the results of federal observational surveys from this same time period indicated that the proportion of Tennessee surveyors with below satisfactory ratings in investigative skills and deficiency determination was more than double the national average. A new director took over the state survey agency in October 2007 and, due to the surveyor performance issues and staff turnover, brought in CMS regional office staff to assist in retraining all of the state's surveyors.

Unlike these seven states, about 93 percent of Alabama's nursing home surveys in fiscal year 2007 were not completed within the maximum 15.9 month interval. In a June 2007 letter to the state, CMS described these results as alarming and asked Alabama to develop an action plan in 2007 to address persistent weaknesses in state performance. The agency used both comparative and observational data from federal monitoring surveys to highlight persistent weaknesses in the survey process to Alabama state officials. Although CMS recognized that the state's inability to complete surveys could be due to staffing levels, salaries, and other issues, CMS ultimately concluded that Alabama needed to improve organization, management, and oversight of all regulatory systems and functions.

⁵⁸See [GAO-08-517](#).

CMS Oversight of States' Use of Funds Is Limited

CMS oversight of states' use of funds for survey activities is limited. To oversee how states spend federal funds, CMS regional offices we spoke with now rely primarily on off-site reviews of state reports documenting their expenditures and workload, but there are limitations to relying on such reports, including their accuracy. In eliminating the budget and financial standard from annual state performance reviews in 2006, CMS redefined these financial responsibilities as core state functions, but not all regional offices we reviewed are attempting to hold states accountable for ensuring the appropriate application of costs to Medicare, Medicaid, and state licensure programs. We also found that regional offices we spoke with had taken a variety of approaches to determining non-Medicaid contribution rates for the states in their regions. Most told us that these rates have not been reviewed in recent years, even though federal survey and state licensure requirements may have changed over time. Regional officials told us that they do not verify that states actually contributed funds in a manner consistent with their shares, noting limits on their authority to require state data and states' refusal to provide it voluntarily. However, CMS assumes that the cost for a state to operate a survey program is higher than the amount CMS provides them and the agency is convinced that states were likely contributing more than their fair share to survey activities. Finally, most regional offices we spoke with do not require states to justify requests for supplemental Medicare funds. As a result, it is difficult for CMS to determine whether expenditures in excess of a state's initial Medicare allocation represent the state's non-Medicaid share of survey costs.

Regional Office Oversight Now Relies on State-Reported Data

To oversee states' use of federal funds for survey activities, the five CMS regional offices we spoke with now rely primarily on the off-site review of reports on expenditures, workload, and survey hours that states submit during the fiscal year, but reliance on such reports for financial oversight has limits.⁵⁹ CMS's central office believes that the majority of the analyses regional offices are expected to perform as part of their oversight can now be accomplished using the reports states submit. In contrast, officials from four of the five CMS regional offices we spoke with generally told us that in the 1990s, they either conducted more formal, on-site reviews or more detailed reviews of systems, such as those used for time and effort reporting, which served as the basis for states' allocations of survey costs

⁵⁹Of the 28 states that we contacted, only 2 reported to have been audited by CMS regional office officials since 2000.

to Medicaid, Medicare, and state licensure programs. This allowed regional offices to verify the accuracy of states' expenditures and ensure that states complied with financial procedures established by CMS.

Effective fiscal year 2006, CMS eliminated the state performance review standard that focused on states' budget practices and financial reporting and redefined these financial responsibilities as "core" functions that states were required to perform. As a part of the state performance review, the state's budget practices were evaluated against 14 elements to determine if the state used acceptable methods for (1) charging the federal programs, and (2) monitoring the current rate of expenditures and planned workload. Two of these 14 elements dealt with the appropriate application of program contribution rates across Medicare, Medicaid, and state licensure programs. Specifically, states must provide reasonable assurances that survey and certification costs were appropriately applied to the Medicare, Medicaid, and state licensure programs for all items and costs in their budgets and across providers and suppliers and the various types of facilities. According to CMS, however, regional offices are still expected to ensure that states are fulfilling their responsibilities under the standards, but only one of the five regional offices we spoke with (San Francisco) determines whether or not it has reasonable assurances that survey and certification program costs are appropriately applied to Medicare, Medicaid, and state licensure programs. Two other regional offices (Chicago and Dallas) inspect state records regarding the application of program costs across the three programs, but do not determine reasonable assurance of this accounting. Two regional offices (Atlanta and New York) have not incorporated these two elements into a review of this standard and its oversight of state survey activities.

Relying primarily on state-reported expenditure data for federal financial oversight has limits. Since fiscal year 2002, states have been required to submit their financial information electronically through a Web-based, automated reporting system provided by CMS. Regional office officials have expressed concern regarding whether state expenditures are accurately reported through this system, as there have been instances where errors were discovered in states' expenditure reports well after their submission. For example, Washington state officials told us that they identified a significant error on the state's expenditure report for fiscal year 2006. In reporting the amount of staff time it took to complete its workload, the state provided the data in terms of months, though it was required to provide staff time in years. As a result, the information in the expenditure report was contradictory. In addition, officials from the Dallas regional office told us that Texas underreported its expenditures in fiscal

years 2003 and 2004 due to errors that resulted as the state transitioned to a new accounting system. The error was not discovered until the Medicare funds the state appeared not to have spent had been reallocated to other states. Officials from the Chicago regional office told us that it is difficult to verify the figures presented on state expenditure reports because of delays by many states in entering information into OSCAR, which regional offices may use to verify states' expenditures. Also, a lack of timeliness in reporting such information can limit regional office oversight efforts. For example, in its review of Delaware's survey expenditures for fiscal years 1998 and 1999, HHS's OIG found that, in addition to not having sufficient internal controls for preparing accurate reports of its Medicare and Medicaid expenditures, the state did not file its fiscal year 1999 expenditure reports on time.

Non-Medicaid State Contributions Are Based on Long-standing Rates That Are Not Reviewed and Vary Greatly by CMS Regional Office

The contribution rates for states in the five regions we spoke with were determined using different methodologies and in most cases have not been reviewed in recent years. Moreover, states are not required to report their non-Medicaid state expenditures to CMS and, as a result, the agency has no way of verifying that states are contributing their own funds appropriately. Nonetheless, CMS central office and regional office officials we spoke with generally assume that the cost of conducting survey activities is greater than the federal funds provided. Consequently, they believe states are contributing more than their fair share to the cost of survey activities and that the exact amount of the non-Medicaid state contribution is less important.

CMS guidance reflects the complexity of establishing equitable state shares and acknowledges that regional office staff must be knowledgeable about state licensure requirements to negotiate states' non-Medicaid contribution rates. For 21 states, the non-Medicaid state share for nursing homes ranged from 12 to 48 percent (see table 6). Regional offices we spoke with have taken a variety of approaches to setting these rates. In some regions, regional office staff determined the rates, while in other regions the states determined the rates themselves.

Table 6: Range of Medicare, Medicaid, and Non-Medicaid State Contribution Rates (as a percentage) for Nursing Home Survey Activities for 21 States, as of January 2008

	Medicare	Medicaid	Non-Medicaid State
Minimum	28	21	12
Median	34	36	25
Maximum	53	51	48

Source: GAO analysis of state-reported data.

Note: Although 28 states responded to our inquiries, this table excludes 7 states that did not report percentages or whose reported percentages could not be summarized. One state reported its non-Medicaid state contribution rate, but did not report its Medicare and Medicaid contribution rates.

- Officials from the Chicago regional office told us that the methodology used by their staff to determine state contribution rates was complex and involved determining a separate state share for each facility type that was surveyed. Regional office staff took into consideration the number of surveys that each state needs to conduct in a given year, the average amount of time each survey should take, and how much of a benefit each state derived from having to conduct the survey.
- Officials from the San Francisco regional office told us that contribution rates for the states in their region are mostly based on historical figures, as reported in states' time and effort record keeping systems.
- Officials from the New York regional office told us that their staff and state officials jointly determined that Medicare, Medicaid, and state licensure programs derived equal benefit from federal nursing home surveys conducted by states in the region. As a result, they concluded that each program should be responsible for one-third of the cost of these surveys. In contrast to what other regions told us, however, states in this region do not have a non-Medicaid state share for other facility types.
- Officials from the Atlanta regional office told us that they played no role in establishing these rates and were unaware of the process states in their region used to determine them.
- Officials from the Dallas regional office told us that, due to the complexity involved in determining an appropriate state share, states in their region do not have pre-established non-Medicaid state contribution rates. Instead, a staff person reviews state surveyor salaries and makes sure that states have apportioned them appropriately between federal and state licensure activity, based on the surveyors' workload from the previous year.

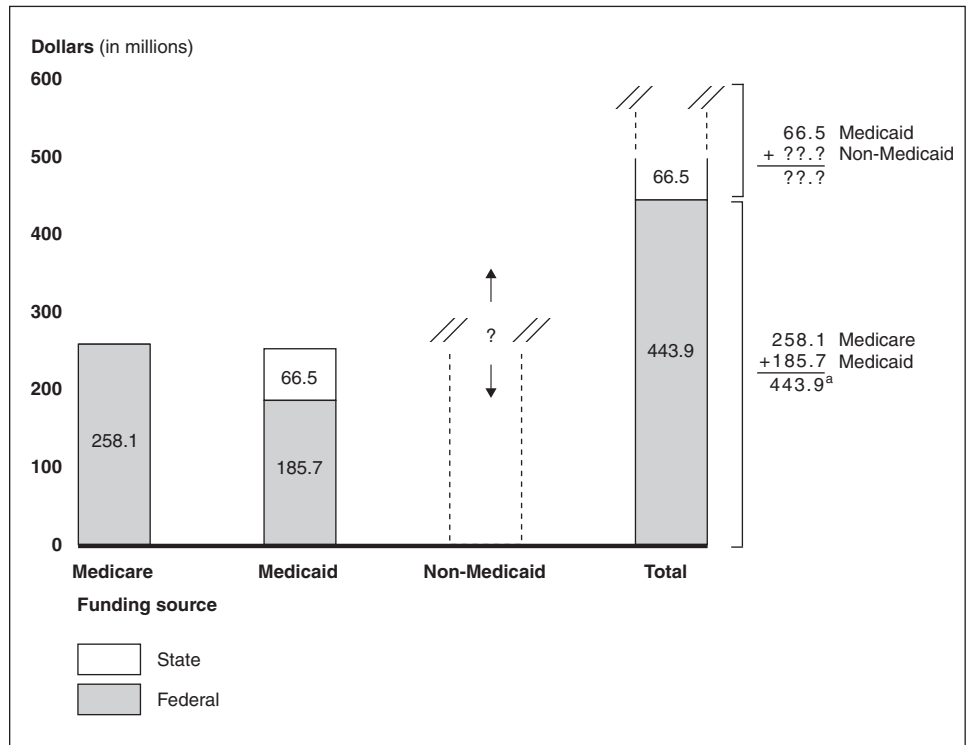
Officials from four CMS regions indicated that the rates for states in their regions are not regularly reviewed and in one case have not been reviewed since they were established. CMS guidance does not prescribe how often the rates should be updated given changes in requirements for federal and state licensure surveys over time. A 2002 HHS OIG review also found that states in four of the five regions it reviewed allocated survey costs based on predetermined, historical contribution rates. Because these rates were established in prior years, documentation of the basis for the rates was not available.

CMS officials told us that the agency does not collect information from states on their non-Medicaid survey expenditures. As a result, CMS does not know if states are contributing their own funds appropriately (see fig. 6).⁶⁰ CMS officials noted limits on the agency's authority to collect state data, particularly regarding licensure activities. In addition, states are not willing to voluntarily disclose information on state funding.⁶¹ For example, officials from the Dallas regional office told us that Texas officials indicated the Dallas officials were not entitled to this information when they requested it. However, information on state expenditures could be relevant to federal oversight of state survey activities in certain situations. For example, if a state requests supplemental funding for shared survey activities—that is, those not exclusively conducted for purposes of state licensure—having information on the state's expenditures for the non-Medicaid share could be relevant in evaluating whether survey costs are equitably shared and that Medicare is not paying more than its fair share for survey activities.

⁶⁰Officials from several of the regional offices we spoke with told us that in the past staff used to conduct on-site audits to verify states' non-Medicaid state spending on survey activities. Staff would interview budget personnel and review a sample of surveyor time records to evaluate how states accounted for their Medicare funds and to obtain assurance that the state had done so appropriately.

⁶¹According to a 2002 HHS-OIG report, HHS's Office of General Counsel concluded that the agency could not require states to disclose information on state funding of their licensure activities. See HHS, Office of Inspector General, *Results of Survey and Certification Review*, A-05-00-00020 (May 31, 2002).

Figure 6: Federal and State Funding for State Survey Activities in Fiscal Year 2007



Source: GAO analysis of CMS data.

^aNumbers do not sum due to rounding.

Most Regional Offices We Interviewed Do Not Require States to Justify Requests for Supplemental Medicare Funds

Though officials from CMS’s central office told us that regional offices should require states to justify any requests for supplemental Medicare funds they submit, three of the five regional offices we interviewed told us that they do not require states to do so. Without an examination of state justifications, it would be difficult for CMS to know if expenditures in excess of states’ initial Medicare allocations represent their non-Medicaid share of state costs.

According to CMS guidance, states can request supplemental Medicare funds in two ways. They can submit a memo to their regional office that includes the amount of funds requested and a detailed rationale for why the funds are needed. A second method is for states to include actual Medicare expenditures in excess of their allocation on the expenditure report they submit at the end of the fiscal year. The state is eligible to

receive supplemental Medicare funding as reimbursement for the portion of these expenditures that exceeds the amount in Medicare funds CMS allocated to it during the fiscal year. According to CMS central office officials, both the memo and the amounts reported on states' expenditure forms are subject to review and approval by the regional offices prior to the funding of states' supplemental requests.

Central office officials told us that the amount of Medicare supplemental funds requested each year has been substantially more than the amount of funds available to redistribute. Consequently, CMS expects that regional offices will use their judgment regarding the intensity of reviews so that they are not spending time reviewing requests that will not be funded anyway.⁶² The level of review conducted by three of five regional offices we interviewed was limited. Officials from the New York regional office told us that their staff checks to see whether a state completed its workload and if the state's expenditures reflect what was included in its budget plan. Officials from the Atlanta and Chicago regional offices said that they do not require documentation or conduct audits to verify these requests. However, officials from the Dallas and San Francisco offices told us that their staff follows up with states to verify their need for supplemental funding, such as asking states for documentation to justify their expenditures in excess of their initial Medicare allocations. On at least one occasion, the Dallas region told CMS that some of a state's requested money should be disallowed because the state conducted tier 4 work before completing work in a higher priority tier.

Conclusions

The current approach for funding state surveys of facilities participating in Medicare and Medicaid is ineffective—yet these surveys are meant to ensure that these facilities provide safe, high-quality care. We found serious weaknesses in CMS's ability to (1) equitably allocate more than \$250 million in federal Medicare funding to states according to their workload, (2) determine the extent to which funding or other factors affected states' ability to accomplish their workload, and (3) guarantee appropriate state contributions. These weaknesses make assessing the adequacy of funding difficult.

⁶²For example, central office officials told us that when regional offices reviewed fiscal year 2007 supplemental requests, one region recommended that a state receive \$399,786 in supplemental funding, though it requested \$1,363,901. Central office officials told us that even this reduced request may not be funded due to the limited amount of Medicare supplemental funds available for the fiscal year.

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- **CMS has made limited progress in ensuring that federal Medicare allocations reflect state workloads.** Since 2000, CMS has taken several steps in response to relatively flat, inflation-adjusted federal funding for state surveys, but these efforts have had little impact. Reducing funding for support contracts—such as one to develop and implement a new nursing home survey methodology to improve the consistency and efficiency of state surveys—provided only about 1 percent more funding to states in fiscal years 2006 and 2007. In our view, the delay in implementation of the QIS is problematic and CMS and beneficiaries would benefit from its implementation well before 2014. Increasing the time between surveys for many facility types had almost no impact on state workloads and state officials believed many facilities were already surveyed too infrequently. Asking states to develop funding contingency plans could not resolve the problem that states do not know their final Medicare allocations until late in the fiscal year, which can hamper efforts to effectively manage state resources. In addition, while Congress did not provide CMS authority to charge facilities for revisit surveys in fiscal year 2008, revisit fees could offer (1) Medicare Trust Funds savings if they result in reductions of amounts that would be otherwise transferred, and (2) somewhat more predictable funding to the extent the fees do not require annual appropriations. Oversight of clinical labs, which pay user fees, provides a precedent for facility contributions to defray the cost of survey activities.
 - CMS took these steps because it believed that Medicare funding had not kept pace with state workloads. But we found that the required survey workload actually decreased from fiscal years 2000 to 2007, suggesting that resources available in fiscal year 2007 were similar to or slightly greater than those in fiscal year 2000 given the modest 4 percent increase in inflation-adjusted federal funding. Nevertheless, because state allocations have been based on historical spending, CMS believes that some states have too much funding given their workload while others have too little. The budget analysis tool that CMS developed to align survey funding with state workloads has been used only incrementally to address state funding inequities, rather than adjusting the mismatch between federal allocations and states' current survey workloads. We believe that CMS's concerns about the instability that would be created if it changed baseline funding for state survey activities could be mitigated through other means. For example, CMS could limit the annual adjustments on states with shrinking baselines to a fixed percentage of each state's historical funding baseline. In addition, CMS lacks adequate data on states' complaint workloads, a significant weakness in its ability to ensure that it is requesting adequate Medicare funding. Moreover, agency officials believed that the amounts identified for complaint investigations in

connection with the President's budget request had not fully funded state complaint surveys.

- **It is difficult to determine the extent to which funding and other factors affected states' ability to accomplish survey workloads.** Twenty-three of the 28 states we contacted told us that more funding was needed and many of these states said that RN salaries were not competitive, which created workforce instability. Although states set surveyor salaries, Medicare allocations that do not support salary increases could result in states' laying off staff, further limiting their ability to accomplish survey workloads. For some states that did not spend their initial allocations, the inability to spend their full allocations rather than the level of funding may interfere with workload completion. Most states told us that underspending was the result of insufficient staff due to retention problems or state hiring freezes. Other states spent more than their initial Medicare allocations and still failed to complete their survey workload. Even if states complete their workload, ensuring that facilities comply with federal quality and safety standards is not guaranteed. For example, seven states completed their nursing home surveys in fiscal year 2006, but CMS found that they missed serious deficiencies on more than a quarter of federal comparative surveys.
- **CMS lacks information on state contributions, which impedes an overall assessment of the resources available for state surveys.** While CMS knows states' Medicare and Medicaid spending, including requests for supplemental federal funding, it has no way to ensure that states contribute their fair share of non-Medicaid state funds. Non-Medicaid state shares for nursing homes vary widely across states, state contribution rates are not determined consistently, and CMS officials do not collect information on such state expenditures. But CMS officials said the agency assumes that the cost of conducting all required surveys is greater than the federal funds provided, so the exact amount each state contributes is less important. Further, states in most regions we interviewed were not required to justify supplemental funding requests. Without examining state justifications, CMS cannot be sure that spending above states' initial Medicare allocations represents their non-Medicaid state share of survey costs.

The evidence is mixed on whether federal funding has kept pace with the changes in states' required survey workload—the workload that states would have to complete to meet statutory and CMS survey frequency requirements. On the one hand, the required survey workload decreased nationwide. On the other hand, most states told us that survey frequencies of 6 to 10 years for many facilities could adversely affect beneficiaries.

Moreover, it is often difficult to distinguish the impact of funding, staffing, and management on state workloads overall. We believe that these and other limitations of the current funding approach will continue to frustrate CMS's efforts to support and oversee state survey activities.

Recommendations for Executive Action

To address significant shortcomings in the current system for financing and conducting surveys of Medicare and Medicaid facilities, we recommend that the CMS Administrator take the following nine shorter-term actions.

To help ensure that those facilities that have not been surveyed in at least 6 years are in compliance with federal quality standards, we recommend that the CMS Administrator take the following two actions:

- Increase the survey priority assigned to such facilities in the annual instructions given to state survey agencies with the goal of surveying them as quickly as possible.
- Monitor the progress made by state survey agencies that have a significant number of such facilities.

To ensure that Congress has adequate information on the impact of funding on facility oversight, we recommend that the CMS Administrator take the following two actions:

- Inform Congress of the projected cost of surveying all facilities that lack statutorily mandated survey frequencies a minimum of at least once every 3 years.
- Include information in the President's budget request on projected state complaints and the cost of completing the associated workload.

To help address state survey funding inequities, we recommend that the CMS Administrator:

- Use available tools to adjust the annual baseline Medicare allocations provided to each state.

To improve CMS's ability to differentiate between funding and management issues and help ensure the quality of surveys, we recommend that the CMS Administrator take the following two actions:

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- Identify appropriate methodologies to help evaluate the efficiency and effectiveness of state survey activities. One such methodology may be the new Quality Indicator Survey, developed to help ensure the consistency, efficiency, and effectiveness of state nursing home surveys. Explore the feasibility of using a similar methodology to survey other Medicare and Medicaid facilities.
 - Provide Congress with an estimate of the cost of implementing, over 3 years, the Quality Indicator Survey methodology for nursing homes.

To improve the oversight of state expenditures, we recommend that the CMS Administrator take the following two actions:

- Collect information about current state shares, including the methodologies used to determine them and the date that they were last reviewed.
- Regularly review state shares to ensure that they are accurate, explore ways to obtain information from states on non-Medicaid expenditures where such information is relevant for ensuring that costs are actually shared on an equitable basis, and consider ways to simplify the process of determining state shares.

Over the longer term, we are also recommending that the CMS Administrator undertake a broad-based reexamination of the current approach for funding and conducting surveys of Medicare and Medicaid participating facilities. This reexamination should consider issues such as (1) the source and availability of funding, including possible imposition of user fees, and (2) ways of ensuring an adequate survey workforce with sufficient compensation to attract and retain qualified staff.

Agency and AHFSA Comments and Our Evaluation

We provided a draft of this report to HHS for comment. In response, the Acting Administrator of CMS provided written comments. We also received written comments from AHFSA. CMS's and AHFSA's comments are reproduced in appendices VI and VII, respectively.⁶³ Although CMS disagreed with elements of our survey workload analysis, the agency concurred with 9 of our 10 recommendations. For 2 of these, we

⁶³During the course of our work, we collected information from 28 states. AHFSA agreed to provide us with consolidated comments on our draft report on behalf of all states.

recommended that CMS provide Congress with certain information and the agency indicated that it would do so upon Congress' request. CMS partially concurred with 1 of our 10 recommendations. While the agency agreed to produce special follow-up reports and have its regional offices contact states with a significant number of facilities that have not been surveyed for lengthy periods, it did not agree to increase the survey priority assigned to facilities that have not been surveyed in at least 6 years with the goal of surveying them as quickly as possible. Instead, CMS noted that the agency had expanded its risk-based approach in fiscal year 2008 such that the maximum tier 3 survey frequency is a 7-year interval (down from an 8-year average). Additionally, for those facilities that have not been surveyed in 7 years and that are identified with certain risk factors, CMS will consider these facilities as part of the tier 2 targeted surveys. As noted in our draft report, many state officials told us that the survey frequency for all facilities that are not set by statute should be every 2 to 3 years. CMS concurred with our recommendation to inform Congress of the projected cost of surveying these facilities a minimum of at least once every 3 years. We continue to believe that all 2,700 facilities that had not been surveyed in more than 6 years as of September 30, 2007 (900 in 10 years or more), should be inspected as soon as possible, regardless of their risk factors. Finally, AHFSA also disagreed with elements of our survey workload analysis, specifically our treatment of complaints and enforcement actions. CMS's and AHFSA's comments and our evaluation are summarized below.

Funding trends. CMS noted that surveys are the principal quality assurance system for Medicare and that the portion of the Medicare budget devoted to quality assurance decreased from 0.1 percent in fiscal year 2000 to 0.06 percent in fiscal year 2008. CMS commented that by combining Medicare and Medicaid federal funding in our draft report, we obscured the differences between the two funding sources and the different decisions that face the Congress and executive branch. We reported aggregate federal funding in our draft report because it is the total federal funding available to support state survey activities. However, we reported Medicare and Medicaid funding levels separately for fiscal years 2000 through 2007 in appendix III and described in the background section how both Medicare and Medicaid fund state survey activities.

Examining the change in states' required survey workload. CMS commented that our basic approach to examining the change in states' required survey workload from fiscal years 2000 through 2007 was sound, but disagreed with some elements of our analysis. AHFSA also disagreed with a few elements.

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- *Use of tier 3 priorities.* CMS commented that we understated the number of facilities subject to state surveys in fiscal year 2007 and omitted other survey activities, such as initial surveys of new providers, which are a tier 4 priority. As we noted in our draft report, however, the nationwide survey workload would still have declined from fiscal year 2000 to fiscal year 2007 if we included tier 4 surveys. Because CMS's four-tier structure for prioritizing states' survey workload did not exist in fiscal year 2000, we used the fiscal year 2000 survey frequencies required by CMS policy. For fiscal year 1999, CMS's budget for survey activities was increased significantly and CMS expected states to complete all surveys. Our draft report pointed out that CMS subsequently established a system for distinguishing between (1) its policy on survey frequencies (essentially those for fiscal year 2000), and (2) the survey priorities, as reflected in its tier structure, to which it holds states accountable for meeting each year in its state performance reviews. For the latter, CMS officials told us that they based their reviews on the requirements in tiers 1 through 3 because they did not believe funding was adequate to survey facilities that were a tier 4 priority. CMS adopted priorities because of the concern that resources were insufficient to accomplish all of the survey workload but maintained its policy on survey frequencies. CMS's comments indicate that states that conduct initial surveys of new providers (a tier 4 priority) before completing all surveys in tiers 1 through 3 may be required to submit a plan of correction and, in addition, there could be other consequences. As such, our workload analysis for fiscal year 2007 used the survey priorities for which CMS held states accountable in its state performance reviews during that fiscal year—tier 1 through 3 priorities.
 - *Differentiating between Medicare and Medicaid.* CMS attempted to replicate our survey workload analysis but separated it by the source of funding—Medicare and Medicaid. CMS concluded that the Medicare-funded workload increased by up to 20 percent from fiscal year 2000 to fiscal year 2007. First, because we were attempting to measure states' overall required workload, we did not differentiate between funding streams. While the results of CMS's analysis are not inconsistent with ours, the net effect remains a decrease in states' required survey workload when the Medicaid workload is considered. Thus, we reported that the decline from fiscal year 2000 to fiscal year 2007 in the number of nursing homes and intermediate care facilities for the mentally retarded, whose surveys receive significant Medicaid funding, offset overall increases in other facilities, whose surveys are largely Medicare-funded, because the two facility types are comparatively the most resource-intensive facilities to survey. Second, in replicating our methodology to incorporate the effect of survey hours on workload, CMS used average survey hours by facility type for fiscal year 2000. As noted in our draft report, because the yearly CMS

survey hour data were not consistent or reliable, we calculated national average survey hours for each facility type for all fiscal years from 2000 through 2007. We used these national averages in our analysis for both fiscal years 2000 and 2007. This could account for some of the difference between CMS's and our results.

- *Inclusion of 2008 data.* CMS commented that our analysis did not include data for fiscal year 2008 and, as such, may not accurately reflect states' current workload. Our analysis was limited to the change in states' required survey workload from fiscal year 2000 to fiscal year 2007 because fiscal year 2008 data were not available when we conducted our analysis. Wherever possible, we tried to note recent CMS initiatives or regulations that could potentially affect workload, including recent regulations requiring organ transplant center programs to be surveyed and new survey requirements for hospices and end-stage renal disease facilities. AHFSA commented on the costs associated with implementing additional CMS requirements, such as new survey protocols and data-entry time frames. However, CMS's comments acknowledged that not all of the workload associated with its recent initiatives can be quantified.
- *States' complaint workload.* Both CMS and AHFSA commented that our analysis of the change in states' required survey workload did not adequately account for the work associated with investigating complaints. AHFSA noted that when its members were surveyed, those states that responded indicated an overall increase in complaint growth over the last 5 years. AHFSA's response did not quantify the increase. CMS commented that the number of complaints investigated on-site increased by about 13.1 percent from fiscal years 2005 to 2007. In our draft report, we acknowledged that complaint investigations represented a significant portion of states' workload. Although CMS implemented a new complaint tracking system in fiscal year 2004, officials told us that the agency lacks complete and reliable data on complaints received and investigated. For example, in our draft report we noted that CMS believes some states may be overestimating by 15 percent the number of complaints investigated by reporting those complaints received and investigated during standard surveys in the complaints database. We included in our draft report a recommendation that the CMS Administrator include information in the President's budget request on projected state complaints and the cost of completing the associated workload and the agency concurred with our recommendation.
- *Enforcement workload.* AHFSA commented that our analysis did not account for the workload associated with enforcement activities. The association noted that decoupling states' responsibilities to conduct

surveys, complaint investigations, and enforcement follow up is impossible. As noted in our draft report, CMS (1) did not have reliable and complete data on revisit surveys from fiscal years 2000 through 2004 and (2) data for fiscal years 2005 through 2007 showed that the revisit workload declined by 4 percent. Because revisits are an indication of enforcement actions, we believe that states' enforcement workload also decreased.

- *Length of an efficient survey.* Finally, CMS commented that we did not address how long a survey should take to achieve a quality result. In its written comments, CMS noted that the only relevant hard data are for survey hours that CMS regional office staff devote to federal comparative surveys and that, for nursing homes, these surveys are typically 15 percent to 25 percent longer than the average state survey time. As noted in our draft report, CMS officials told us that they did not know how long an efficient survey should take and could not assess whether the considerable interstate variation in the length of surveys was appropriate. Comparative surveys may not be the best measure of how long a survey should take. Indeed, many officials from the states we contacted during the course of our work told us that comparative surveys were not a good measure. Moreover, our May 2008 report found that when the number of surveyors and time on-site are taken together, federal comparative surveys averaged 12.9 surveyor-days and the corresponding state surveys averaged 12.6 surveyor-days in fiscal year 2007.

CMS oversight and state performance standards. CMS commented that in fiscal year 2000, the base year of our analysis, there were few consequences for poor performance and few, if any, effective national measures of survey performance. CMS highlighted the improvements it had since made to its performance system, which we noted in our draft report. CMS commented further that its overall approach to accountability is to communicate workload priorities by organizing them into tiers, initiate consequences for unacceptable performance, and match the strength of consequences with the priority and importance of the work. We acknowledged CMS's efforts to link states' performance to workload priorities and, as a result, we focused on changes in the workload that CMS holds states accountable to complete.

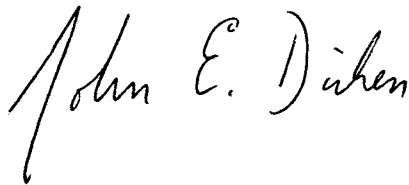
Future trends. CMS believed that the Medicare-funded survey workload is likely to continue to increase and that, given the overall federal budget situation, it is imperative that the agency design survey methodologies that leverage resources to ensure maximum productivity and effectiveness. CMS highlighted examples of such productivity enhancements, including

implementing the Quality Indicator Survey methodology for conducting nursing home surveys nationwide, targeting resources to surveys of the most at-risk facilities, and investing in methodologies that help states address their staffing barriers. AHFSA also noted staffing challenges, such as (1) vacant or frozen surveyor positions and (2) a lack of cross-trained surveyors who can survey more than one type of facility. We noted some of these initiatives and challenges in our draft report and, to the extent that we were able, we indicated how these issues might affect states' survey workload. We also made specific recommendations to the CMS Administrator for improving the agency's ability to differentiate between funding and management issues and to help ensure the quality of surveys.

CMS and AHFSA also provided technical comments, which we incorporated as appropriate.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Administrator of the Centers for Medicare & Medicaid Services and appropriate congressional committees. The report also will be available at no charge on the GAO Web site at <http://www.gao.gov>.

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



John E. Dicken
Director, Health Care

Appendix I: Scope and Methodology

This appendix provides a more detailed description of our scope and methodology.

Centers for Medicare & Medicaid Services (CMS) budget and expenditure data. To identify the trends in federal funding for survey activities, we reviewed the President's budget request and analyzed federal funding for survey activities CMS expended for survey activities from fiscal years 2000 through 2008.¹ We selected fiscal year 2000 because of the significant increase in funding for survey activities for fiscal year 1999 to support an increased workload associated with the Nursing Home Oversight Improvement Program. We also analyzed data provided by CMS on state survey expenditures from fiscal years 2000 through 2007, including the provision of supplemental funds to states that spent more than their initial Medicare allocations by redistributing unspent state allocations. To understand the Medicare funding allocation process, we reviewed CMS's State Survey and Certification Budget Call Letters or Mission and Priority Documents for fiscal years 2000 through 2008; CMS uses these documents to (1) provide instructions to states on preparing budget requests for federal funds, (2) communicate anticipated federal Medicare funding levels to states, and (3) communicate state survey priorities based on the requested funding. We also discussed the survey budget process with CMS officials, including their use of the Budget Analysis Tool, which the agency began using in 2005 to better calibrate federal funding with states' survey workloads. Because of its limited use, we did not evaluate the tool's effectiveness. To gain a state and regional office perspective on the budget process and how it had changed over time, we interviewed regional office officials as well as state officials in two states that spent more (Florida and New York) and two states that spent less (Ohio and Washington) than their initial Medicare allocations for fiscal years 2000 through 2006 and reviewed periodic state expenditure reports.

CMS databases on state survey activities. To determine the extent to which states completed their survey workloads, we analyzed CMS data on the results of the fiscal year 2006 state performance review, the most

¹We used the gross domestic product price index to adjust for inflation during this time period.

recent data available at the time we conducted our analysis.² We subsequently compared state completion rates to those from the fiscal year 2007 review when that data became available. In addition, we used CMS's On-Line Survey, Certification, and Reporting (OSCAR) system data to determine the number of facilities with survey frequencies established by CMS that states had not surveyed within 6 and 10 years.

We also used OSCAR and CMS documents for fiscal years 2000 and 2007³ to examine changes in states' required survey workload—the workload that states would have to complete to meet statutory and CMS survey frequency requirements. We then analyzed the effect of the following three factors on states' required survey workload: (1) changes in the number of facilities subject to state surveys including state validation surveys of accredited facilities, (2) changes in intervals between surveys from fiscal year 2000 to fiscal year 2007 for facility types that lack statutory survey time frames, and (3) differences in the time devoted to surveys across facility types. First, we calculated the proportion of each facility type subject to standard and validation surveys in every state based on survey frequency requirements for fiscal years 2000 and 2007.⁴ Second, we multiplied this result by national average survey hours for each facility type to estimate survey workload in hours and computed the percentage change in the required survey workload between fiscal years 2000 and 2007 (see app. V). We used national average hours instead of state average survey hours for each facility type because surveys for many facility types were too infrequent at the state level to produce reliable data. We asked CMS to provide the survey hour data because OSCAR data on state-

²State performance reviews evaluate states' completion of CMS survey priorities, a four-tier structure for prioritizing surveys and adjusting nonstatutory survey frequencies to reflect available funding with tier 1 being the highest and tier 4 the lowest priority. State performance reviews hold states accountable for completing surveys in tiers 1 through 3, but not tier 4.

³Data available for the number of facilities in fiscal years 2000 and 2007 were archived in December of the respective fiscal years.

⁴Survey frequencies set by statute were the same in fiscal years 2000 and 2007. The tier structure for prioritizing states' survey workload did not exist in fiscal year 2000 and most nonstatutory survey frequencies were between 6 and 7 years (see app. II). For fiscal year 2007, we used the same survey frequencies that CMS uses to assess states' abilities to meet the agency's survey priorities, which ranged from about 4 years to 10 years (see app. II). However, even if we had used CMS's policy for fiscal year 2007, which is 6 years for most facilities lacking statutory survey time frames, the nationwide survey workload would still have declined.

specific survey hours was incomplete for fiscal years 2000 through 2004.⁵ Because we used national average survey hours, our analysis does not reflect differences in average facility size across states; it also does not reflect any differences in survey hours over time. Although CMS survey hour data from fiscal years 2000 to 2007 showed an increase of about 4 percent overall, this increase was not gradual from year-to-year and the increases and decreases could not be explained. Therefore, we determined that the yearly survey hour data were not consistent or reliable. In assessing how states' survey workload changed over this time period, we also considered state complaint investigations, survey process improvements that increased survey hours, and facility revisits required to ensure that serious deficiencies had been corrected. We did not attempt to incorporate these state survey activities into our workload analysis because the data lacked reliability and consistency and the increases in survey hours were modest for most facility types.

CMS oversight of states' use of federal funds. To assess the effectiveness of CMS oversight of states' use of survey funds, we reviewed CMS's *State Operations Manual*, which sets expectations for both CMS regional offices and states on budgeting and expenditure reporting. We also examined CMS's state performance review protocols, which included a standard on state budget practices and financial reporting, and several audits of states' survey expenditures conducted by the Department of Health and Human Services (HHS) Office of Inspector General in fiscal years 2001 and 2002.⁶ We discussed expectations of how CMS regional offices should carry out oversight with central office officials and staff from five regional offices and also obtained the perspective of state officials.

⁵OSCAR only retains data for the four most recent surveys, roughly fiscal years 2005 through 2008 for nursing homes, but longer for facilities that are surveyed less frequently.

⁶HHS, Office of Inspector General, *Commonwealth of Virginia Department of Health, Section 1864-1902 Survey and Certification Costs for Health Care Providers and Suppliers: October 1, 1997 – September 30, 1999* (August 2001); HHS, Office of Inspector General, *State of Delaware Department of Health and Social Services, Section 1864-1902 Survey and Certification Costs for Health Care Providers and Suppliers: October 1, 1997 – September 30, 1999* (November 2001); and HHS, Office of Inspector General, *Results of Survey and Certification Review* (May 2002).

State perspectives. During early data collection for this study, we interviewed state officials from Florida, New York, Ohio, and Washington on issues such as the survey budget process, reasons for over- or underspending federal Medicare allocations, completion of CMS workload priorities, state licensure requirements, and staff recruitment and retention. Subsequently, we sent e-mail questionnaires to 27 other states covering similar issues as well as questions on federal oversight, and we followed up with the 4 states already interviewed. We used five factors to select these additional states, which follow.

- **Expenditure of federal Medicare allocations.** We selected states that spent at least 5 percent more or less than their total federal Medicare budget from fiscal years 2000 through 2006 and whose total over- or underspending was at least \$500,000. At the time of our state selection, data for fiscal year 2006 were the most recent data available.
- **Accomplishment of CMS workload priorities.** We selected states that accomplished 50 percent or fewer of CMS's workload priorities in tiers 1 through 3 for fiscal year 2006. At the time of our state selection, data for fiscal year 2006 were the most recent data available.
- **Quality of nursing home surveys.** To gauge the quality of states' nursing home surveys which most states were able to complete, we analyzed the results of federal comparative surveys conducted from fiscal years 2002 through 2007 using CMS's federal monitoring survey database. We reported the results of this analysis in May 2008.⁷ We selected states in which at least 25 percent of federal surveys found that state surveys had missed serious deficiencies.
- **Number of facilities.** Using CMS's OSCAR database, we selected states that had experienced an increase or decrease of at least 20 percent in the number of facilities from fiscal years 2000 through 2006.⁸ At the time of our state selection, data for fiscal year 2006 were the most recent data available.

⁷GAO, *Nursing Homes: Federal Monitoring Surveys Demonstrate Continued Understatement of Serious Care Problems and CMS Oversight Weaknesses*, [GAO-08-517](#) (Washington, D.C.: May 9, 2008).

⁸By grouping the states into three clusters for fiscal year 2006—small (500 or fewer facilities), medium (between 500 and 2,000 facilities), and large (2,000 or more facilities)—we ensured that we had selected several states in each cluster. We included 7 of the 7 large states, 12 of the 27 medium states, and 9 of the 17 small states.

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- **Geographic distribution.** We selected at least two states from each of the 10 CMS regions.

Twenty-four of the 28 additional states responded to our e-mail questionnaire; considering the 4 states contacted initially, we collected information from a total of 28 states. In addition, we also interviewed officials from the Association of Health Facility Survey Agencies, an organization that represents state survey agencies.

Data reliability. We verified the consistency and reliability of documentations and data that CMS provided through various means. On the basis of CMS's documentation, we determined that CMS's data on state survey expenditures from fiscal years 2000 through 2007 were reliable for examining state expenditures and the allocation of supplemental funds to states. We determined that CMS's state performance reviews were reliable to understand states' completion of CMS survey priorities because CMS uses this information for the same purpose. In addition, CMS generally recognizes OSCAR data to be reliable and throughout the course of our work we discussed our analysis of OSCAR data with CMS officials to ensure that the data accurately reflected state survey activities. We tested the data provided by CMS on survey hours for consistency and compared the data to survey data from OSCAR. We also interviewed CMS officials to learn about how they use the data and to clarify any data discrepancies. We reviewed state-reported data for consistency and plausibility and followed up with state officials to retrieve missing data and resolve data inconsistencies. In general, we determined that the data provided by the states were accurate for our purposes.

Appendix II: CMS Survey Frequency Changes for Facilities Surveyed by States, Fiscal Years 2000 through 2008

Table 7 shows the overall survey frequencies by facility type against which CMS measures each states' completion of its survey workload. In fiscal year 2006, in response to available Medicare funding, the agency began adjusting survey frequencies for facility types that lack statutory survey time frames. According to CMS officials, these adjustments did not alter its policy on survey frequency, which remains at about every 6 years for most facilities with nonstatutory survey frequencies.

Table 7: CMS Survey Frequency Changes for Facilities Surveyed by States, Fiscal Years 2000 through 2008

Type of facility	Fiscal year 2000	Survey frequency			
		Fiscal years 2001-2005	Fiscal year 2006	Fiscal year 2007	Fiscal year 2008
Survey frequency established by statute					
Home health agency ^a					
Nonaccredited home health agency	3 years	3 years	3 years	3 years	3 years
Intermediate care facility for the mentally retarded	Annually	Annually	Annually	Annually	Annually
Nursing home ^c	Annually ^c	Annually ^c	Annually ^c	Annually ^c	Annually ^c
Survey frequency established by CMS					
Ambulatory surgical center ^a					
Nonaccredited ambulatory surgical center	6.67 years	6 years	8 years	10 years	7 years
Accredited ambulatory surgical centers ^b	N/A	5 percent ^e	5 percent	5 percent	5 percent
Comprehensive outpatient rehabilitation facility	6.67 years	6 years	8 years	10 years	7 years
End-stage renal disease facility	6.67 years	3 years	3.5 years	4 years	4 years
Home health agency ^a					
Accredited home health agency validation surveys ^b	N/A	5 percent	5 percent	5 percent	5 percent
Hospice ^a					
Nonaccredited hospice	6.67 years	6 years	8 years	10 years	7 years
Accredited hospices ^b	N/A	5 percent ^e	5 percent	5 percent	5 percent
Hospital ^a					
Nonaccredited hospital	9 years	3 years	4.5 years	4.5 years	4.5 years
Accredited hospitals ^b	5 percent	1 percent ^f	1 percent	1 percent	1 percent
Organ transplant center ^d	N/A	N/A	N/A	To be determined	3 years
Outpatient physical therapy	6.67 years	6 years	8 years	10 years	7 years
Portable X-ray service	6.67 years	6 years	8 years	8 years	7 years

**Appendix II: CMS Survey Frequency Changes
for Facilities Surveyed by States, Fiscal Years
2000 through 2008**

Type of facility	Survey frequency				
	Fiscal year 2000	Fiscal years 2001-2005	Fiscal year 2006	Fiscal year 2007	Fiscal year 2008
Psychiatric residential treatment facility ^b	N/A	5 years ^g	5 years	5 years	5 years
Rural health clinic	6.67 years	6 years	8 years	10 years	7 years

Source: CMS.

Note: In fiscal years 2000 and 2001, CMS required that states survey an established percentage of providers for a given provider type (e.g., 15 percent). CMS changed this requirement in later years to intervals (e.g., every 6 years). In order to allow comparison among years, we present the 2000 and 2001 requirements in intervals (e.g., every 6.67 years) instead of percentages (e.g., 15 percent). Requirements for fiscal years 2006 through 2008 reflect CMS's survey priorities as established in tiers 1 to 3.

^aThese facility types can choose to be inspected by an accrediting organization, such as the Joint Commission, or by states. Nearly 80 percent of ambulatory surgical centers and 85 percent of hospices were surveyed by states as of fiscal year 2007.

^bThere are two types of state validation surveys that evaluate accreditation organizations' ability to ensure facilities' compliance with Medicare quality standards: (1) representative sample surveys, which are standard surveys conducted shortly after an accreditation organization survey in order to assess the accreditation organization's survey process, and (2) complaint surveys, which are used to identify the compliance of the accredited facility with selected regulatory requirements noted in the complaint received by CMS. This table reflects representative sample validation surveys. In the case of a psychiatric residential treatment facility, state surveys verify that the facility is in compliance with its attestation concerning the use of restraints.

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

^dIn 2007, CMS issued a regulation that requires organ transplant center programs to be surveyed. These surveys will be phased in over a 3-year period, beginning in 2007. See 42 C.F.R. § 488.61 (2008).

^eAccredited ambulatory surgical centers and hospices did not have an established rate for their validation surveys until 2002.

^fThe rate for representative sample validation surveys of accredited hospitals changed from 5 percent to 1 percent in 2003.

^gAccredited psychiatric residential treatment facilities did not have an established rate for their representative sample validation surveys until 2002 and in 2003 validation surveys were done for 5 percent of facilities.

Appendix III: Federal Funding for Survey Activities in Actual and Inflation-Adjusted Dollars, Fiscal Years 2000 through 2007

Table 8: Federal Funding for Survey Activities (in millions), Actual Dollars, Fiscal Years 2000 through 2007

Fiscal year	Medicare	Medicaid	Total
2000	\$209.7	\$146.7	\$356.4
2001	242.1	162.2	404.4
2002	253.1	172.2	425.3
2003	252.7	164.1	416.8
2004	251.3	169.8	421.0
2005	258.7	177.4	436.1
2006	258.1	183.7	441.8
2007 ^a	258.1	185.7	443.9
Change from 2000 to 2007	23.1%	26.6%	24.5%
From 2000 to 2002			19.3%
From 2002 to 2007			4.3%

Source: CMS.

^aNumbers do not sum due to rounding.

Table 9: Federal Funding for Survey Activities (in millions), Inflation-Adjusted to Fiscal Year 2000 Dollars, Fiscal Years 2000 through 2007

Fiscal year	Medicare	Medicaid	Total
2000	\$209.7	\$146.7	\$356.4
2001	236.6	158.5	395.1
2002	242.6	165.1	407.7
2003	237.5	154.1	391.6
2004	230.1	155.5	385.6
2005	229.6	157.4	387.0
2006	221.7	157.8	379.5
2007	215.9	155.3	371.2
Change from 2000 to 2007	3.0%	5.9%	4.2%
From 2000 to 2002			14.4%
From 2002 to 2007			(9.0%)

Source: GAO analysis of CMS data.

Appendix IV: Number of and Percentage Change in Facilities Subject to State Standard and Validation Surveys, 2000 to 2007

Type of facility	Number of facilities		Change (percentage change)
	December 2000	December 2007	
Facilities subject to state standard surveys			
Ambulatory surgical center	2,959	3,865	906 (31)
End-stage renal disease facility	3,951	5,050	1,099 (28)
Hospice	2,169	2,746	577 (27)
Home health agency	6,569	7,909	1,340 (20)
Rural health clinics	3,334	3,781	447 (13)
Comprehensive outpatient rehabilitation facility	518	535	17 (3)
Outpatient physical therapy or outpatient speech pathology services	2,871	2,913	42 (1)
Hospital	2,086	2,187	101 (5)
Intermediate care facility for the mentally retarded	6,767	6,443	-324 (-5)
Nursing home	16,946	15,827	-1,119 (-7)
Portable X-ray service	675	550	-125 (-19)
Organ transplant center ^a	0	254	254 (N/A)
Psychiatric residential treatment facility	0	87	87 (N/A)
Total	48,845	52,147	3,302 (7)
Facilities subject to state validation surveys			
Home health agency	557	1,326	769 (138)
Hospice	66	471	405 (614)
Ambulatory surgical center	169	1,072	903 (534)
Psychiatric residential treatment facility	0	185	185 (N/A)
Hospital	4,607	4,434	-173 (-4)
Total	5,399	7,488	2,089 (39)
Overall	54,244	59,635	5,391 (10)

Source: GAO analysis of CMS data and Organ Procurement and Transplantation Network data.

^aThe total number of organ transplant centers is as of January 2008; collectively these centers operated 844 organ transplant programs. Each transplant center may have more than one organ-specific program, each of which will be surveyed separately.

Appendix V: Change in States' Required Survey Workload from Fiscal Year 2000 to Fiscal Year 2007

In order to determine how states' required survey workload—the workload that states would have to complete to meet statutory and CMS survey frequency requirements—has changed from fiscal year 2000 to fiscal year 2007, we analyzed OSCAR and CMS data for fiscal years 2000 and 2007. First, we determined percentage changes in the number of facilities subject to state surveys, including state validation surveys of accredited facilities. Second, we combined the effects of the number of facilities subject to standard and validation surveys with the survey frequency requirements for fiscal years 2000 and 2007. Third, we incorporated the effect of survey hours for each facility type using average national survey hours to determine the change in states' required survey workload between fiscal years 2000 and 2007. States are listed from highest to lowest based on the percentage change in the number of facilities subject to surveys.

Table 10: Percentage Change in Number of Facilities Subject to State Surveys, Number of Surveys Each State Is Expected to Conduct, and Required Survey Workload after Factoring in National Survey Hours, Fiscal Years 2000 and 2007

State	Percentage change in number of facilities subject to surveys	Percentage change in number of surveys each state is expected to conduct ^a	Percentage change in required workload ^b
Nevada	36.4%	3.4%	-1.7%
Utah	35.8%	16.6%	7.1%
Florida	31.1%	11.5%	1.0%
Texas	26.2%	7.2%	0.5%
Michigan	24.4%	-1.0%	-2.1%
Mississippi	18.8%	7.2%	7.8%
Missouri	16.7%	-2.5%	-5.5%
Arizona	16.5%	0.0%	-4.5%
Washington	16.3%	-9.1%	-11.1%
Delaware	14.2%	2.0%	2.7%
Illinois	13.7%	1.0%	-4.0%
Alabama	12.6%	1.8%	2.5%
Georgia	12.2%	2.8%	1.3%
Nebraska	12.2%	0.7%	-1.8%
Colorado	12.1%	-2.0%	-4.4%
Oregon	12.0%	-3.5%	-6.5%
Kentucky	11.4%	-2.3%	-4.3%
Idaho	11.4%	-2.7%	-4.5%

**Appendix V: Change in States' Required
Survey Workload from Fiscal Year 2000 to
Fiscal Year 2007**

State	Percentage change in number of facilities subject to surveys	Percentage change in number of surveys each state is expected to conduct^a	Percentage change in required workload^b
New Jersey	10.7%	0.4%	0.2%
Louisiana	10.2%	2.1%	-3.4%
Virginia	9.8%	5.3%	0.8%
Ohio	7.3%	-1.4%	-3.5%
California	6.5%	0.6%	-2.7%
Oklahoma	5.9%	-1.9%	-9.6%
North Carolina	5.1%	4.9%	3.5%
Iowa	4.1%	-0.4%	-1.3%
New Mexico	4.0%	-3.0%	-5.5%
South Carolina	2.8%	-15.7%	-10.5%
Maryland	2.8%	-8.8%	-9.6%
Tennessee	2.4%	-8.9%	-8.6%
Pennsylvania	1.8%	-6.0%	-6.8%
Kansas	1.7%	-8.5%	-8.9%
New Hampshire	0.9%	-2.5%	-1.3%
Indiana	0.9%	-7.2%	-8.6%
South Dakota	0.6%	-1.4%	-1.0%
Arkansas	0.1%	-5.6%	-6.6%
Connecticut	-0.2%	-4.5%	-5.1%
Alaska	-2.0%	-0.6%	4.4%
Hawaii	-3.7%	-3.8%	-0.2%
Wisconsin	-3.8%	-8.7%	-7.0%
West Virginia	-4.8%	0.5%	-2.9%
Massachusetts	-4.8%	-13.2%	-14.9%
Montana	-5.1%	-9.1%	-8.9%
Minnesota	-5.4%	-11.3%	-10.3%
Wyoming	-6.3%	-6.0%	-1.8%
Vermont	-7.6%	-11.1%	-8.7%
Maine	-8.1%	-15.3%	-11.3%
District of Columbia	-8.1%	-9.9%	-8.7%
New York	-8.7%	-11.8%	-7.7%
North Dakota	-10.1%	-4.1%	-2.7%
Rhode Island	-13.1%	-21.8%	-17.2%

**Appendix V: Change in States' Required
Survey Workload from Fiscal Year 2000 to
Fiscal Year 2007**

State	Percentage change in number of facilities subject to surveys	Percentage change in number of surveys each state is expected to conduct^a	Percentage change in required workload^b
Nation	9.0%	-1.9%	-4.2%

Source: GAO analysis of CMS data.

^aThe total number of surveys each state is expected to conduct in a given year is calculated by summing the product by facility type of the (1) number of facilities and (2) survey frequency.

^bRequired workload for each state in a given year is calculated by summing the product of (1) number of facilities, each facility type, (2) average survey hours of all surveys conducted from 2000 through 2007 in the U.S., each facility type, and (3) survey frequency, each facility type.

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



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

JAN 21 2009

John E. Dicken
Director, Health Care
U.S. Government Accountability Office
441 G Street N.W.
Washington, DC 20548

Dear Mr. Dicken:

Enclosed are comments on the U.S. Government Accountability Office's (GAO) report entitled: "MEDICARE AND MEDICAID PARTICIPATING FACILITIES: CMS Needs to Reexamine Its Approach for Funding State Oversight of Health Care Facilities (GAO-09-64).

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

Sincerely,

A handwritten signature in cursive script that reads "Barbara Pisaro Clark".

Barbara Pisaro Clark
Acting Assistant Secretary for Legislation

Attachment

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

TO: John Dicken
Director, Health Care
Government Accountability Office

FROM: Kerry Weems
Acting Administrator

SUBJECT: Government Accountability Office (GAO) Draft Report: Medicare And Medicaid Participating Facilities: CMS Needs to Reexamine Its Approach for Funding State Oversight of Health Care Facilities (GAO-09-064)

Thank you for the opportunity to comment on the subject GAO Draft Report, prepared at the request of the Special Committee on Aging and the Committee on Finance. The objectives of this report are to determine--

1. What changes have occurred in the survey and certification budget since the 1999 increase in funding to implement the Centers for Medicare & Medicaid Services' (CMS) nursing home initiatives?;
2. To what extent has funding kept pace with the growing CMS and State workload?;
3. Are sufficient resources being directed towards oversight of all Medicare and Medicaid providers?; and
4. Should these resources be increased, redirected, or otherwise modified?

While there are many useful recommendations in the report, there are some serious issues with the methodology used in the workload analysis section for survey & certification (S&C). For example, the mixing of Medicare and Medicaid workloads into one summary statistic obscures the fact that the Medicare workload is increasing while the Medicaid workload is decreasing. Since Medicare and Medicaid must be budgeted and cost-accounted separately, distinct workload calculations are necessary for the two funding sources.

The report also uses different standards to measure the workload in fiscal year (FY) 2007 compared to FY 2000. For FY 2007 the GAO analysis artificially truncated the workload at the "Tier III" priority level, thereby omitting "Tier IV" work such as initial surveys of many new providers. In FY 2000 CMS did not provide such priority guidance to States, and the GAO used all surveys in the FY 2000 "base year" calculation. The different methodology applied to the 2 years results in an "apples to oranges" comparison that can be misleading. We hope that our explanation of these and other aspects of the report, described in more detail in the following pages, can help to clarify important trends and provide a clear sense of budget issues and choices.

The report contains many useful recommendations, all of which we will adopt in whole or in part, as noted below in our responses to the GAO recommendations.

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CMS Comments

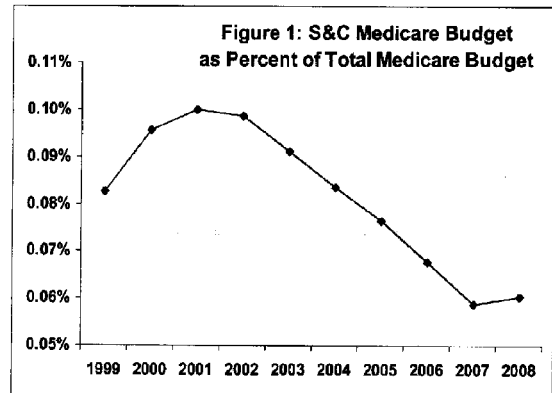
The S&C is the principal quality assurance system for Medicare (as well as important aspects of Medicaid). Trained and objective State and Federal surveyors make onsite reviews of each provider to identify quality problems and hold providers accountable for failure to meet Federal standards for patient safety and quality of care. About 81,000 providers are subject to onsite surveys, and about 104,000 surveys are conducted each year (including complaint investigation surveys¹).

What percentage of the Medicare program ought to be devoted to Medicare quality assurance?

The answer depends upon the level of oversight and quality assurance that Congress and the Executive Branch believe is needed to assure basic quality, and the level that the Nation can afford compared with other priorities.

In the late 1990s Congress addressed itself to this issue, expressing serious concern with the level of Medicare quality assurance. Congress and the Administration subsequently increased the S&C Medicare portion of the Medicare budget to 0.10 percent.

Beginning in FY 2005, however, actual appropriations have been well below the President's Medicare budget requests for S&C. The cumulative difference between the President's budget request and final appropriation for the 4-year period FY 2005-2008 amounted to \$52 million. The S&C Medicare proportion of the overall Medicare budget declined substantially until the 110th Congress arrested the decline in 2008. Figure 1 shows the bottoming out of the percent devoted to Medicare quality assurance as it declined from 0.10 percent of the overall Medicare budget in FY 2000 to 0.06 percent in FY 2008.



Funding Trends in Detail

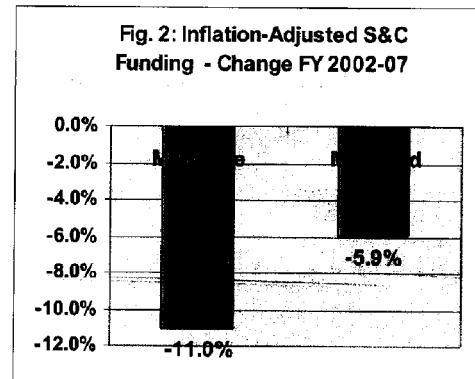
The GAO observes that "In inflation-adjusted terms, funding increased modestly by 4 percent over the entire eight fiscal years [from FY 2000 to 2007], but fell 9 percent from fiscal years 2002 through 2007."²

¹ The totals also include about 10,500 surveys for about 21,000 clinical laboratories that are surveyed under a user-fee system pursuant to the Clinical Laboratory Improvement Amendments (CLIA).
² Page 16 of draft GAO report.

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The GAO figures reflect the combined total of Medicare and Medicaid. A clearer picture of trends emerges when Medicare and Medicaid are identified separately. For Medicaid, the inflation-adjusted funding declined by 5.9 percent³ from FY 2002 to 2007. For Medicare, the inflation-adjusted funding for S&C declined by 11.0 percent. Figure 2 shows these recent trends⁴.

Isolating the different funding trends in Medicare and Medicaid is important because the Medicaid portion of the S&C workload has declined modestly, but the Medicare portion has increased while inflation-adjusted funding has decreased. In addition, the Federal share of Medicaid is part of mandatory Medicaid spending law. (Social Security Act: Title XVIII, section 1864 (Medicare - discretionary funding), Title XIX, section 1919 (Medicaid - mandatory funding). For the Medicare portion of S&C funding Congress considers the President's budget request each year in the appropriation process, and may approve the requested level or indicate a different level.



Summary statements throughout the report that combine Medicaid and Medicare into a single finding (for the analyses of both workload and funding) serve to obscure the important differences between the two and the different decisions that face the Congress and Executive Branch.

GAO Workload Analysis

The GAO analysis of the S&C workload is based on (a) multiplying the number of providers in FY 2000 for each provider type (e.g., nursing homes), times (b) the frequency of surveys that CMS policy called for in that FY (e.g., once per year), times (c) the average number of hours for each survey for each different type of provider. The GAO then made the same calculations for FY 2007 using 2007 data, except for holding the average hours per survey constant at the FY 2000 level so as to isolate the workload changes. The two results are then compared. While this basic approach is sound, there are a number of methodological problems in its implementation:

❖ **Apples to Oranges Comparison:** The GAO used one standard for the frequency of surveys in FY 2000, and then used a different standard for FY 2007. In specific: for FY 2000 (the base year in the comparison) GAO used all CMS priority "Tiers," but for FY 2007 used only Tiers 1-3⁵. This artificially truncated the FY 2007 workload numbers and omits a variety of survey activities, including initial surveys of many new providers.

³ See Appendix III, draft GAO report

⁴ The GAO analysis did not include FY 2008, during which Congress approved 2/3 of the President's requested S&C increase. This reduced the inflation-adjusted decline for Medicare to about -5.6% (instead of -11%) from FY 2002 to 2008.

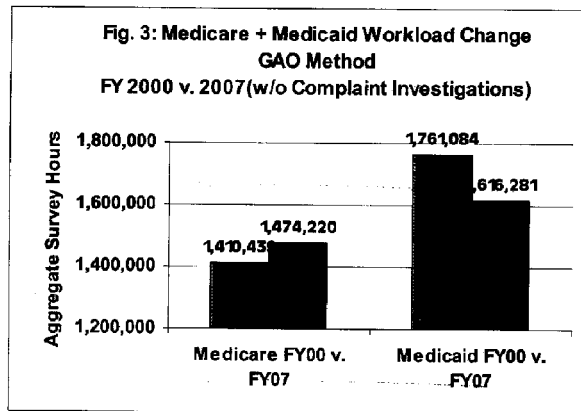
⁵ Technically, CMS did not have an articulated priority "Tier" structure in place in FY 2000. So the GAO used all frequencies articulated in CMS policy. For FY 2007, however, GAO ignored the authoritative source of CMS budget direction to the States (the Mission & Priority document), and chose to omit "Tier IV" frequencies from their analysis. The rationale apparently is that only the first 3 Tiers are included in CMS State Performance Standards System (SPSS). But the SPSS did not exist in FY 2000. Hence GAO applied different standards to FY 2007 compared to FY 2000.

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- ❖ **Obscuring the Medicare Trends and Implications:** We recommend that the GAO clarify the difference between the Medicare and Medicaid survey workloads. As with the funding trends, combining Medicare and Medicaid workloads into a single workload statistic obscures the fact that the Medicare workload has gone up while it is the Medicaid workload that has gone down.
- ❖ **Increased Medicare Regulations:** Because GAO's analysis did not include FY 2008 data, the report does not reflect improved regulation of key provider types such as the first-ever regulation and survey process for hospital transplant centers effective June 28, 2007 (currently about 878 centers), and the new regulation for dialysis facilities, effective October 14, 2008.
- ❖ **Ignoring Complaint Investigations:** The GAO correctly observes that reliable complaint investigation numbers for both received and investigated complaints is not available for the full time period under consideration (FY 2000 through 2007). However, such data are available for 2005-2007 after CMS improved its system for recording and tracking complaints. These data are useful in considering future workload implications.

Since funding for Medicare and Medicaid workloads must be budgeted and cost-accounted separately, the most useful workload analysis is one that identifies the separate dynamics affecting each funding source.

Figure 3 shows the workload change from FY 2000 through 2007 for Medicare in the first two bars, using GAO's methodology of holding the FY00 average hours per certification survey constant and calculating and comparing the FY) and FY07 workloads, while the second two-bar set portrays the same information for Medicaid using our best estimate of the GAO methodology and number of providers. In short, the Medicare workload went up (by 4.5 percent) while the Medicaid workload went down (by 8.2 percent). The Medicaid workload has diminished primarily due to (a) deinstitutionalization efforts by States that have reduced their Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) in favor of home and community-based services, and (b) a substantial decline in the number of Medicaid-only nursing homes.



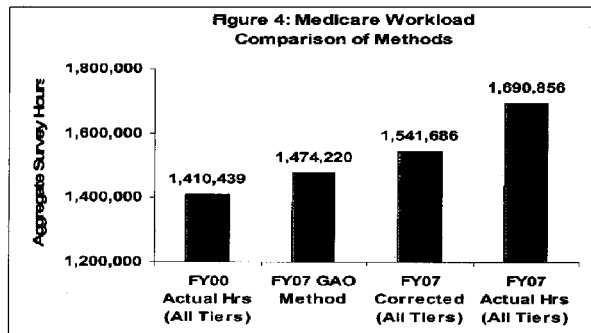
It is clear from Figure 3 that Medicaid's 8.2 percent workload reduction obscures the 4.5 percent Medicare workload increase when the two sets of figures are combined into one summary workload statistic.

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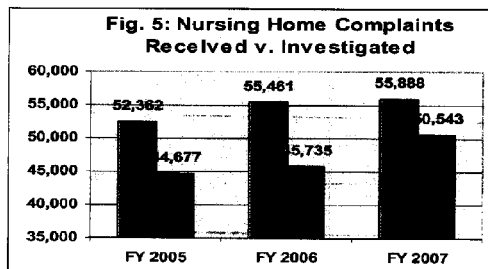
CMS Workload Analysis

Figure 4 shows the different conclusions one would reach if more of the methodological considerations are taken into account. Focusing on Medicare, the first column (FY00) shows the Medicare workload using the GAO methodology for FY 2000. The second column (FY07 GAO Method) shows the FY 2007 Medicare result, using our best estimate of the GAO methodology that includes only Medicare survey frequencies at the Tier III level (omitting Tier IV and omitting Medicaid). In this column FY 2000 hours per survey for each provider type were used to control for any difference in survey hours between FY 2000 and FY 2007.

The third column in Figure 4 (FY 07 Corrected (All Tiers)) shows the result if all four priority Tiers were used for FY 2007 (thus restoring an apples to apples comparison with FY 2000). In this column, FY 2000 hours per survey were also used to control for any difference in survey hours. The column shows a 9.3 percent increase in Medicare workload compared to FY 2000.



The last column is the same as the third column (all priority Tiers are included) except that it uses FY 2007 actual average hours per survey for each provider type rather than holding the hours constant at the FY 2000 level. This perspective may be useful because it may partially incorporate the effects of increased Medicare regulations. This column shows an increase in workload of 19.9 percent compared to FY 2000.



Finally, the GAO analysis did not incorporate two other considerations. First, the workload associated with complaint investigations was not incorporated because CMS does not have data going back to FY 2000 on the number of complaints received (as opposed to just the number of complaints actually investigated). This precluded comparison with the GAO base year of FY 2000.

But CMS does have recent data following implementation of the new Aspen Complaint Tracking System (ACTS) in FY 2004. The data indicate a slight but consistently upward trend in the complaint workload. The left side bars in Figure 5 show the number of complaints received in each year. The number increased by about 6.7 percent from FY 2005 to FY 2007. The right side bars in each year show the number of complaints actually investigated onsite by State survey agencies. The number increased by about 13.1 percent from FY 2005 to FY 2007 (from 44,677 to 50,543).

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Second, the GAO report does not address the question of how long a survey should take to achieve a quality result. The only relevant hard data that exist are data on the number of hours per survey that CMS regional office staff devotes to Federal Monitoring Surveys, sometimes called comparative or "validation" surveys. Such surveys are conducted within 60 days after a State survey. CMS regional offices compare the Federal findings with the State findings to identify differences between the two. The regional offices then provide follow-up and oversight to the State survey agencies. For nursing homes, Federal surveyors typically spend 15-25 percent more time conducting and completing the Federal Monitoring Survey compared to the average State survey time (depending on the State and the region). However, to expect that States spend the same amount of time as Federal surveyors would significantly increase the projected workload.

CMS Oversight and State Performance Standards System

The GAO rationale for using only Tiers I-III in its FY 2007 workload calculations appears to rest on its belief that only frequencies included in CMS' State Performance Standards System (SPSS) ought to be considered as a workload. If we are correct, then the rationale would lead to the untenable belief that there was no workload in the "base year" of FY 2000, since neither the priority Tiers nor the SPSS existed at that time. It would also imply that CMS should not pay for Tier IV work (since it would not count as "workload"). Similarly, if the GAO had done its review in 2004 using its current methodology, it would have concluded that there was no workload associated with dialysis facilities, ambulatory surgical centers, hospices, and other non-long-term care providers since they were not included in the SPSS at that time.

The GAO also implies⁶ that CMS only holds States accountable for priority Tiers I-III (thereby omitting initial surveys and other Tier IV work)⁷. This would be an incorrect assumption. The real accountability question is how the States are held accountable for performance, and how effective that accountability system is at promoting performance. Instead of an "all or nothing" approach, CMS correlates accountability consequences with the priority Tiers.

In the GAO's base year of FY 2000 there were few consequences to poor performance, and few (if any) effective national measures of survey performance. Since that time CMS implemented, and continuously improved, a performance system that in many ways may be a model for intergovernmental relations between the Federal and State Governments.

2000-2002: CMS notified States, on July 14, 2000, of its intention to develop State performance standards and formed workgroups with States to do so. On April 6, 2001, CMS issued standards and review protocols for CMS Regional Offices (ROs) to follow (via Memorandum S&C-01-11). The focus was on nursing homes.

⁶ Page 6 of the draft.

⁷ CMS introduced the priority Tiers to ensure closer alignment between State performance and CMS priorities. Tier I encompasses primarily the statutorily-required frequencies. Tier II contains such items as extended surveys pursuant to complaint investigations, most validation surveys to check on the adequacy of surveys by accrediting organizations, and "targeted surveys." Under the Tier II targeted survey system, States conduct high priority surveys on a sample of providers for which available data indicate a higher risk of poor quality. These include certain home health agencies (5% sample), hospices (5%), dialysis facilities (10%), and ambulatory surgical centers (increased from 5% to 10% effective FY 2009). Tier III contains most remaining standard surveys based on a maximum interval expected between surveys of any one provider. Tier IV contains the remaining surveys based on average frequency, as well as the initial surveys for all new providers that have an accreditation option. The priority Tiers are important for communicating Federal priorities. The SPSS is important for measuring performance in relation to those priorities. CMS correlates accountability consequences in relation to the priority Tiers; greater consequences accrue the more serious the performance issue.

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2003-2004: CMS moved beyond its initial pilot efforts and standardized the performance reviews (via S&C-03-27 and 04-47).

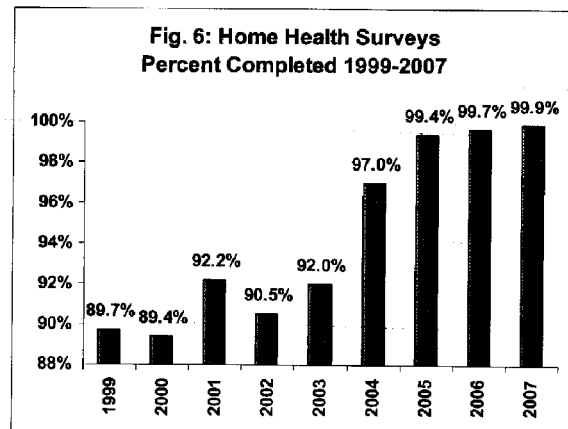
2005-2007: CMS added many more providers to the SPSS, such as ESRD facilities, hospices, ambulatory surgical centers, and other non-long-term care providers. CMS increased the consequences of unacceptable performance by reducing a State's S&C budget allocation when a State fails to perform all statutorily-required surveys. Such "non-delivery deductions" amounted to \$638,699 for FY 2008 performance issues.

2008-2009: CMS further integrated budgetary consequences with performance and communicated the Agency's intention to expand non-delivery deductions to include Tier II targeted surveys.

A more accurate way to view CMS' approach to accountability, therefore, is to appreciate that CMS (a) communicates clear priorities through the priority Tiers, (b) initiates consequences to unacceptable performance, and (c) arranges the strength of accountability consequences to match the priority and importance of the work (as delineated in the priority Tiers). Failure to perform all statutorily-required surveys (Tier I), for example, now results in a reduction to the State's budgetary allocation. Failure to conduct Tier IV work, in contrast, does not result in a budgetary reduction; but it may result in a required plan of correction pursuant to a Federal review that finds resource adequacy, and may result in other consequences if CMS finds that a State performed Tier IV work while neglecting higher-Tiered Federal priorities.

The results of the SPSS and budgetary coordination are perhaps best illustrated in the improved performance of States in conducting surveys of each home health agency at least once every 3 years.

Figure 6 shows the percentage of home health agencies that were surveyed within this statutorily-required timeframe. The performance rose from 89.4 percent in FY 2000 to 99.9 percent in FY 2007.



New, Additional Workload

It is understandable that the GAO report does not include quantitative measures of new workloads recently assumed by the national survey & certification system, as not all of the increased workload can be readily quantified. Nonetheless, the workload additions are very real and are concentrated in Medicare, exemplified by the following examples:

Hospital Transplant Centers: Such centers previously were paid under a Medicare National Coverage Determination (NCD). Except for kidney transplants⁸, the centers were not surveyed,

⁸ It is unknown (and somewhat questionable) how much actual survey work was done previously for kidney transplant centers, as the surveys were generally done in conjunction with the dialysis survey and a separate accountability system for the transplant work did not exist.

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and no Medicare Conditions of Participation (CoPs) existed. On March 30, 2007, CMS promulgated a final rule specifying CoPs for transplant centers, with an effective date of June 28, 2007. (72 FR 15198 (March 30, 2007)) Existing centers had to apply by December 26, 2007 to be surveyed under the new CoPs. Onsite surveys began in September 2007. Approximately 878 centers in about 240-254 hospitals will be surveyed on a once-every-3-year cycle. CMS expects that the entire effort will require about \$1.8 to \$2.2 million per year in addition to information system upgrades.

ESRD Regulations: A comprehensive upgrade of the regulations for End-Stage Renal Disease (ESRD) took effect on October 14, 2008. (73 FR 20370 (April 15, 2008)) New surveys are expanded to encompass both refinements to existing requirements and many new expectations, such as the requirement that every dialysis facility have an internal Quality Assurance and Performance Improvement (QAPI) system. The number of Conditions of Coverage increased from 11 to 16, and the number of Standards within those Conditions increased from 245 to 372.

Hospice Revised Regulation: The final regulation was promulgated in June 2008. (73 FR 32088 (June 5, 2008)) It became effective in December 2008 and added a variety of new standards and conditions. The number of standards for which compliance must be surveyed increased from 47 to 92.

Home Health Branch Locations: CMS expanded the purview of surveyor work to include review of branch locations. The continued and substantial increase in the use of branch locations by Home Health Agencies is outstripping CMS and State ability to provide proper oversight. (State Operations Manual, Chapter 2, Section 2182)

Accrediting Organization (AO) Oversight: The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) replaced the Joint Commission's (JC) automatic and statutory deeming approval under Medicare with the same requirements for CMS review and approval as all other AOs. MIPPA also expanded the required CMS oversight reports to Congress from validation and reporting for just the JC to all AOs.

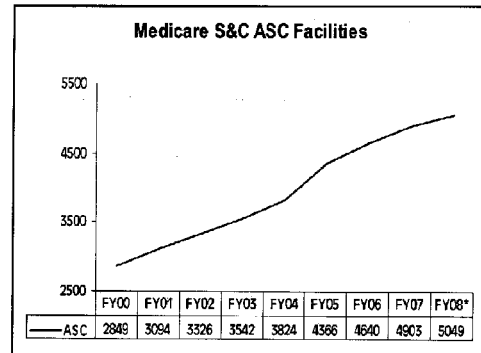
Five-Star Quality Rating System: On December 18, 2008, CMS inaugurated a five-star quality rating system for all nursing homes on the CMS *Nursing Home Compare* Website. Monthly updating and continued improvement to both the rating system and the Website means an increased long-term commitment of resources to ensure a Website that is as accurate, fair, up-to-date, and as informative as possible.

Other: Examples of myriad additional new responsibilities include: new regulations of Organ Procurement Organizations (OPOs), six major expansions of survey guidance for nursing home surveys, and expansion of the Special Focus Facility initiative for nursing homes with a history of persistent and pervasive quality of care problems.

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Future Trends

The trend of increased Medicare workloads is likely to continue. Ambulatory surgical centers (ASCs), for example, increased in number by about 58 percent from 2000 to 2007, dialysis facilities increased by 28 percent, and home health agencies by 30 percent. These trends continue. We are also experiencing continuous requests for initial surveys of new providers for most types of providers and suppliers (predominantly Tier IV work).



Increased concerns about patient safety risks in ASC also led us to develop pilot programs to improve infection control. In 2008 three pilot States integrated a Centers for Disease Control and Prevention (CDC)-designed infection control review instrument into the survey process, a technique that allowed much more effective identification of infection-control hazards.

Those pilot techniques merit expansion beyond the pilot, but would require resources. The advisability of strengthening ASC oversight may be well illustrated by the developments in the State of Nevada in 2008, during which more than 50,000 people were advised to be tested for potential exposure to hepatitis C at the area colonoscopy clinics (certified under the ASC category). CMS and the CDC assisted the State of Nevada in surveying all 50 ASCs in the State, finding that the majority manifested serious deficiencies in practice.

Similarly, both potential fraud and quality of care concerns in some new home health agencies likewise suggest the need for new approaches.

Given the overall Federal budget situation, it is all the more imperative that we design survey methodologies that leverage resources to ensure maximum productivity and effectiveness. Examples of such productivity enhancements include:

CMPs: Collect CMPs while a case is being appealed (rather than only after final disposition), with provision to return all funds plus interest if the judgement is in the favor of the nursing home plaintiff. This would require legislation. See Acting Administrator Kerry Weems testimony before the Senate Aging Committee, May 2007.

Quality Indicator Survey (QIS): The QIS is a revised nursing home survey process that makes use of tablet PC technology and a systematic and objective review of all regulatory areas. The staged survey process includes systematic methods to focus on selected areas for further review once the initial, comprehensive reconnaissance is completed. In this manner the surveyor onsite time is calibrated to enable more time to be spent with nursing homes for which the initial reconnaissance indicates more serious problems, and less time with nursing homes that are performing better. The QIS is being implemented statewide in nine States so far, and is expected to improve consistency in the survey process from State to State and from team to team within a State. However, since the QIS is funded out of the S&C operating budget and

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must compete with the need to ensure basic survey completion for all provider and supplier types, its expansion to other States is very slow.

Quality Assurance and Performance Improvement (QAPI): We believe it is advisable to improve the regulatory expectations for nursing homes to have effectively working, internal QAPI systems similar to other providers, and invest in the development of additional nursing home QAPI capability. This places additional emphasis on internal quality assurance with the hope that external quality assurance (via survey & certification) could then become less necessary.

Targeted Surveys: Increasingly, we seek to target scarce survey resources to those providers and suppliers most at risk. Such targeting of resources could be improved by developing better data sets that can identify emerging quality of care or patient safety problems, particularly in providers such as ASC and hospitals.

State Staffing: The GAO report documents a number of issues that State Survey Agency directors struggle with to attain and maintain a full cadre of qualified surveyors. This makes clear the advisability of investing in methodologies that help State survey agencies address the staffing barriers inherent in State personnel systems.

GAO Recommendations

Below are the GAO recommendations, followed by CMS responses.

Recommendation 1

To help ensure that those facilities that have not been surveyed in at least 6 years are in compliance with Federal quality standards, the GAO recommends that the Administrator of CMS take the following two actions:

A. Increase the survey priority assigned to such facilities [that have not been surveyed in 6 years] in the annual instructions given to State survey agencies with the goal of surveying them as quickly as possible.

CMS Response

Beginning with the FY 2008 Mission and Priority Document, we increased the Tier III priority for these providers to a 7-year maximum interval (from an 8-year average). For those providers that have not been surveyed in seven years, (Tier III priority) and that also are identified with certain risk factors, we afford them special attention in the Tier II targeted surveys to the extent that they do not displace other providers that are more at risk. While this is not yet at the 6-year frequency desired, it is an improvement made pursuant to Congress' action on the FY 2008 budget. Depending on funding availability, we are not likely to move to a six-year interval. Instead, we will focus on further improvements to targeted samples for those providers more at risk.

B. Monitor the progress made by State survey agencies that have a significant number of such facilities [that have not been surveyed in 6 years].

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CMS Response

We agree. We will produce special follow-up reports and CMS regional offices will follow-up with State survey agencies that have a significant number of facilities not surveyed for lengthy periods or that fail to conduct all Tier II targeted surveys of providers at risk.

Recommendation 2

To ensure that the Congress has adequate information on the impact of funding on facility oversight the GAO recommends that the Administrator of CMS take the following two actions:

A. Inform Congress of the projected cost of surveying all facilities that lack statutorily mandated survey frequencies.

CMS Response

Upon request, CMS can provide Congress with technical assistance.

B. Include information in the President's Budget Request on projected State complaints and the cost of completing the associated workload.

CMS Response

We concur.

Recommendation 3

To help address state survey funding inequities, we recommend that the Administrator of CMS use available tools to adjust the annual baseline Medicare allocations provided to each State.

CMS Response

We concur. We will continue to use the Budget Analysis Tool (BAT) to increase equity among States in the availability of Medicare S&C funds, and examine more closely any additional methods by which the process might be improved.

Recommendation 4

To improve CMS's ability to differentiate between funding and management issues and help ensure the quality of surveys, we recommend that the Administrator of CMS take the following two actions—

A. Identify appropriate methodologies to help evaluate the efficiency and effectiveness of State survey activities. One such methodology may be the new Quality Indicator Survey, developed to help ensure the consistency, efficiency, and effectiveness of State nursing home surveys. Explore the feasibility of using a similar methodology to survey other Medicare and Medicaid facilities.

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CMS Response

We concur. We will continue to expand the use of the Quality Indicator Survey (QIS). We will also develop additional tools for improvement designed to enable State supervisors to gain a faster and better factual sense of survey performance by their survey teams, including the development of statistical output reports that are pre-programmed for ready use. We will also invest in a similar technology for end stage renal disease (ESRD) surveys for use with the new ESRD regulation.

B. Provide the Congress with an estimate of the cost of implementing over 3 years the Quality Indicator Survey methodology for nursing homes.

CMS Response

Upon request, CMS can provide Congress with technical assistance.

Recommendation 5

To improve the oversight of State expenditures, we recommend that the Administrator of CMS take the following two actions—

A. Collect information about current State shares, including the methodologies used to determine them and the date that they were last reviewed.

CMS Response

We concur. For FY 2009 we implemented a review process with States to examine all State cost-accounting proportions, as well as the methodologies and tracking systems employed. We expect the results to be available in the summer of 2009.

B. Regularly review State shares to ensure they are accurate, explore ways to obtain information from States on non-Medicaid expenditures where such information is relevant for ensuring that costs are actually shared on an equitable basis, and consider ways to simplify the process of determining State shares.

CMS Response

We concur. We will await the results of our FY 2009 review process (described above) and then determine a frequency by which informational updates would be advisable. We will also analyze methods by which the process of determining State shares might be simplified.

Recommendation 6

Over the long term, the GAO is also recommending that the CMS Administrator undertake a broad-based re-examination of the current approach for funding and conducting surveys of Medicare and Medicaid participating facilities. This re-examination should consider issues such as (1) the source and availability of funding, including possible imposition of user fees, and (2) ways of ensuring an adequate survey workforce with sufficient compensation to attract and retain qualified staff.

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CMS Response

We concur.

The CMS very much appreciates the opportunity that the GAO has afforded us to comment on this draft report and we look forward to working with the GAO on this and other issues in the future.

Appendix VII: Comments from the Association of Health Facility Survey Agencies



Association of Health Facility Survey Agencies
Monitoring the health care of a nation.

January 15, 2009

John E. Dicken
Director, Health Care
U.S. Government Accountability Office
Washington, DC 20548

Dear Mr. Dicken:

Thank you for the opportunity to respond to the Government Accountability Office (GAO) report entitled "Medicare and Medicaid Participating Facilities: CMS Needs to Reexamine Its Approach for Funding State Oversight of Health Care Facilities." The Association of Health Care Facility Survey Agencies (AHFSA) represents state licensing and certification agencies from all 50 States, the District of Columbia, Puerto Rico and the Virgin Islands. AHFSA members are responsible for enforcing standards established by federal legislation, federal regulations, state legislation, and state regulations. We believe that vigorous enforcement of these standards is critical to improving the quality of life and quality of care for health care consumers in our country, and is necessary as well if we are to maintain the improvements already achieved. We believe that the conclusions of the report are faulty because the GAO has failed to fully consider important aspects of survey agency work. This additional work includes survey agency response to public complaints, and enforcement actions against poor providers. These activities are not only required by law, but are critically important to public safety and trust.

AHFSA member agencies conduct periodic, on-site, comprehensive inspections of health care facilities and programs to determine compliance with federal and state requirements. Members of AHFSA also investigate complaints of abuse, neglect, exploitation, poor care, and inadequate practices by health care providers. Providers as well as individuals may suffer criminal prosecution, administrative sanctions, and fines as a result of our investigations and inspections. AHFSA members are actually in the quality assurance arm of the Medicare-Medicaid and state health programs. In conducting this study, the GAO appears to have assumed that various activities performed by the state can be managed as discrete functions. But this is not the reality under which state agencies must work. States are responsible for conducting on-site surveys, complaint investigations, and enforcement follow-up. As is true for any quality

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assurance system, it is impossible to de-couple these three functions. For example, survey findings have a direct relationship to enforcement activities. As deficiency citations become more significant in scope and severity, enforcement remedies, and the administrative and management time required to impose them, likewise become more significant. And, as enforcement increases in significance, supervisory oversight and review of survey findings must become more rigorous to ensure factual findings and conclusions can survive subsequent legal scrutiny.

As another example, because of the time-span between routine inspections, complaints are often the first indicator of developing compliance issues. Complaint surveys can be a fertile source of serious deficiency citations and result in the imposition of more frequent enforcement remedies; as such, they may also consume a lopsided proportion of management and administrative resources. In the day-to-day operations of state survey agencies, the line that distinguishes these quality assurance activities is neither distinct nor static, yet all these activities are equally vital. State agencies are required to make daily, sometimes hourly, operational decisions in which highly trained survey personnel and supervisors may be assigned to any of these functions as there are needs, and as needs are prioritized. We cannot investigate complaints without taking enforcement actions when serious deficient practices are detected. We cannot undertake enforcement without first conducting surveys. We cannot devote all of our resources to periodic surveys because it would cause us to fail to investigate serious allegations of misconduct and harmful care.

The GAO report primarily addressed resources needed for surveys and a portion of required enforcement activities, while giving scant attention to the resources necessary for conducting complaint investigations in a manner that is both effective and responsive. AHFSA cannot endorse an assessment of our workload if it does not plainly consider the significance of complaint investigations as a workload variable. We particularly challenge the conclusion that a decrease in the overall population of any particular provider type will necessarily result in a diminished workload. Unlike mandated routine periodic surveys, which are predictable in number, complaint investigations cannot be "capped" and are unpredictable in number. When AHFSA members were queried, reporting states indicated an overall increase in complaint growth across the last five years. In all settings, the need to conduct complaint investigations within reasonable timeframes has an impact on scheduling, staff morale, and management of resources that is not proportionate to the number of hours required onsite. Previously scheduled surveys are frequently postponed in order to make staff available to investigate a priority complaint on short notice. In the case of non long-term care providers, complaint investigations have particular impact on available resources. A complaint may require a team of highly specialized staff to conduct the investigation, and may trigger a requirement for a full federal survey that was previously unplanned, unscheduled, and unbudgeted.

In the world of regulatory quality assurance, the cost of business for state survey agencies cannot possibly be estimated by calculating only the required number of re-

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certification surveys. The degree of "compliance" by any provider is dynamic, and the state workload attributable to that provider on any given day may vary as changes occur in facility management, ownership, policies, and resident or patient populations. Changes in any of those factors may result in new, unanticipated oversight and enforcement needs. Moreover, the GAO appears to have assumed, for the purposes of this study, that all states have a surveyor workforce composed of individuals who are cross-trained across facility types and who can easily negotiate the transition in survey methodology from one provider type to another. In fact, different provider types require different surveyor specialties, experience, and access to qualified CMS training. CMS funding is often linked heavily to the establishment of state salaries for surveyors. When states increase salaries in order to attract quality candidates, and there is no corresponding increase in the federal match; surveyor positions are potentially left vacant or frozen to account for the difference. This has the effect of limiting available staff resources. Some states may also have structural impediments (i.e. structural splits between acute care and long-term care) which make any transition activity even more difficult.

In addition, there was no clear consideration in the study of infrastructure costs which are not captured on the CMS 670 and for those activities which are required by CMS through administrative procedures or operations. These include demands placed on states by CMS regional office staff, implementation of CMS transmittals with additional survey protocol requirements that were not included in the CMS mission and priority document for the current year, down-time for ASPEN up-grades, and timely data-entry requirements, etc. Non-statutory workloads also have a direct impact on efficiency in accomplishing statutory workloads. Finally, CMS does not include in its budget formula routine costs related to enforcement nor does it fund the entire enforcement cycles that are necessary to meet statutory and regulatory requirements.

Again, thank you for the opportunity to provide comment.

Sincerely,



Polly Weaver, President

Attachment (Technical Corrections)

Appendix VIII: GAO Contact and Staff Acknowledgments

GAO Contact

John E. Dicken, (202) 512-7114 or dickenj@gao.gov

Acknowledgments

In addition to the contact named above, Walter Ochinko, Assistant Director; Kaycee M. Glavich; Leslie V. Gordon; Thomas Han; Keyla Lee; Jessica C. Smith; and Timothy J. Walker made key contributions to this report.

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