United States General Accounting Office

GAO

Report to Congressional Requesters

May 1991

HEALTH CARE

Hospitals With Quality-of-Care Problems Need Closer Monitoring

GAO/HRD-91-40

GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-243451

May 9, 1991

The Honorable Fortney H. (Pete) Stark
Chairman, Subcommittee on Health
Committee on Ways and Means
House of Representatives

The Honorable Dave Durenberger
United States Senate

In letters dated November 2, 1988, and January 2, 1989, you asked several questions relating to the adequacy of federal oversight of the Joint Commission on Accreditation of Healthcare Organizations' accreditation activities in hospitals serving Medicare patients. In a June 1990 report and subsequent testimony,[1] we discussed problems that the Health Care Financing Administration (HCFA) has been encountering in comparing its survey results with those of the Joint Commission and we addressed certain questions you raised with respect to HCFA's survey process. This report expands on that effort and discusses the causes and effects of HCFA's limited oversight of both the Joint Commission's accreditation process and state surveys of nonaccredited hospitals. Responses to your remaining questions are contained in appendix I.

Background

Under the Medicare law adopted in 1965, a hospital was considered to have met the requirements for participation in the Medicare program if the institution was accredited by the Joint Commission. Initially, the Joint Commission accreditation process was not made subject to federal review and Commission survey reports were confidential and available only to Commission personnel and officials associated with the surveyed hospitals. In 1972, the Congress amended the 1965 legislation and authorized the Secretary of Health and Human Services (HHS) to survey a sample of accredited hospitals to determine whether the Joint Commission's process assures that these hospitals meet Medicare conditions of participation.[2] Except for those hospitals surveyed under the authority of the 1972 legislation, the Joint Commission was not required to provide HCFA with any survey report. However, in December 1989,

[1]Health Care: Criteria Used to Evaluate Hospital Accreditation Process Need Reevaluation (GAO/HRD-90-89,June 11, 1990) and HCFA Needs Better Assurance That Hospitals Meet Medicare Conditions of Participation(GAO/T-HRD-90-44, June 21, 1990) presented before the Subcommittee on Health, Committee on Ways and Means, House of Representatives.

[2]Conditions of participation are health, safety, and quality standards for hospitals participating in the Medicare program and are prescribed in the Code of Federal Regulations. There are 20 conditions relating to such areas as quality assurance, nursing services, and infection control.

the Congress enacted Public Law 101-239. The law provided that, effective June 19, 1990, HHS be given access to data relating to Joint Commission surveys of hospitals serving Medicare patients regardless of whether a survey was conducted by HCFA.

The Joint Commission surveys hospitals that seek its accreditation. Surveys are conducted at least once every 3 years using standards developed to assess hospitals' capabilities to provide quality health care. Survey teams, comprised of physicians, nurses, medical technologists, and hospital administrators, examine all services of a hospital and determine the extent of a hospital's compliance with Commission standards. When the teams complete accreditation surveys (usually within 3 to 5 days), they submit a report to the Joint Commission's central office. The reports are analyzed by central office staff to determine if the hospital meets the Commission's accreditation criteria.

Depending on the seriousness of any problems identified, hospitals that do not meet Commission standards can be either denied accreditation, given a conditional accreditation, or given an accreditation with a Type I recommendation for corrective action.[3] Hospitals that are denied accreditation are resurveyed when sufficient evidence is provided to the Commission that the hospital is ready for such an examination. A conditional accreditation is given when deficiencies are widespread and pervasive, and the affected hospital must correct deficiencies within 6 months from the time its plan for corrective action is approved by the Joint Commission. If the problems are not resolved when the Commission conducts its follow-up visit, the hospital's accreditation could be withdrawn. Hospitals receiving Type I recommendations must give corrective action high priority, and the hospital's progress is monitored by the Commission through focused surveys or written progress reviews at specified times over the accreditation cycle. Failure to resolve the problems could lead to accreditation withdrawal.

To validate the Joint Commission's accreditation process, HCFA—using its 1972 legislative authority—randomly selects a small number of hospitals to be surveyed based on the geographic location and size of the hospital. These surveys are conducted within 60 days of the completion of the Joint Commission accreditation survey and include an examination of all conditions of participation. Accredited hospitals can also be

[3]A Type I recommendation represents an area of deficiency in which a hospital is ordinarily expected to achieve substantial or significant compliance with the relevant Commission standard within a specified time.

surveyed if allegations are made by Medicare beneficiaries, their families, or other sources that quality-of-care problems exist in a facility.

On September 7, 1990, the director of HCFA's Health Standards and Quality Bureau informed each HCFA regional office that in fiscal year 1991, the sample selection procedures for validation surveys of the Joint Commission's accreditation process will be modified. In addition to the sample validation surveys, 50 hospitals will be examined annually at various points in their 3-year Joint Commission accreditation cycle to evaluate how well hospitals maintain compliance between surveys. HCFA will also annually survey 25 hospitals that have been conditionally accredited by the Joint Commission to determine how effectively the Commission follows up to assure that problems identified are corrected.

HCFA contracts with state health agencies to conduct the validation and allegation surveys using its guidelines. These surveys generally last from 4 to 5 days, and the state agencies report their findings to HCFA regional office officials who review the data and determine whether the hospital met the Medicare conditions of participation. State agencies will also conduct the surveys required by HCFA under its new survey guidelines.

If a hospital is determined to be out of compliance with one or more conditions, HCFA considers the hospital to be unable to provide high-quality care to Medicare patients. If the noncompliance poses an immediate and serious threat to patient health and safety, HCFA will terminate the hospital from the program if corrective action is not taken within 23 days. If the noncompliance does not pose such a threat, termination will take place if corrective action is not taken within 90 days. HCFA central office analysts receive and compare data from both the Joint Commission and HCFA regional offices on each hospital surveyed to validate the Commission's process.

As we reported earlier,[4] HCFA analysts often find differences in the deficiencies identified by state survey agencies and the Joint Commission. This is primarily due to differences in the scope and content of Medicare conditions of participation and Commission standards, which are the basis for the two organizations' surveys. For example, the Medicare condition of participation relating to nursing services consists of 3 standards and 16 elements. Joint Commission requirements relating to

[4]Health Care: Criteria Used to Evaluate Hospital Accreditation Process Need Reevaluation (GAO/HRD-90-89).

nursing services consist of 8 standards, 47 required characteristics, and over 80 subelements under the required characteristics. Although differences in survey findings do not necessarily mean that the surveys of either the Joint Commission or HCFA are deficient, they can be an indication of potential problems that warrant attention.

Hospitals that choose not to seek Joint Commission accreditation and those that the Joint Commission reviews and from which it withdraws an existing accreditation, are surveyed by state agencies under contract with HCFA. There are approximately 1,300 such hospitals serving Medicare patients. State survey agencies determine which of these hospitals will be inspected in any given year and utilize the same survey criteria that is applied in accredited hospitals. HCFA expects state agencies to survey at least 75 percent of the nonaccredited hospitals in their jurisdictions annually, if funds are available.[5] HCFA conducts a small number of monitoring surveys to assess the performance of state agencies in identifying nonaccredited hospitals that are out of compliance with Medicare conditions of participation.

Results in Brief

HCFA considers hospitals that are out of compliance with one or more Medicare conditions of participation to be susceptible to providing poor quality care. Such hospitals are subject to termination from the Medicare program if compliance is not achieved within a specified period. But HCFA has not been able to accurately determine whether hospitals accredited by the Joint Commission are complying with Medicare conditions of participation. Further, in nonaccredited hospitals, HCFA regional office review teams have found that state agency surveys are not consistently identifying Medicare conditions that are not being complied with. As a result, HCFA cannot be sure that quality health care is being provided to Medicare beneficiaries.

Joint Commission survey reports do not specifically address hospitals' compliance with Medicare conditions of participation. Further, HCFA is uncertain which of its conditions of participation apply directly to Joint Commission standards. But HCFA is working with the Commission to develop a crosswalk that will define the relationship between Medicare conditions of participation and Joint Commission standards. Until this effort is completed, full access to Commission survey data under Public Law 101-239 will not greatly enhance HCFA's overall ability to evaluate

[5]Hospitals that choose not to be accredited by the Joint Commission are called "nonaccredited" by HCFA and "not accredited" by the Joint Commission.

the Commission's effectiveness in assuring that hospitals meet Medicare requirements. The data can, however, be used to track the timeliness of Joint Commission efforts to assure that corrective action is taken in hospitals that are out of compliance with Commission standards and receive a conditional accreditation. Given that hospitals conditionally accredited by the Commission are likely to be out of compliance with Medicare conditions of participation, this tracking capability is significant.

State agencies are not consistently identifying all Medicare conditions that are out of compliance in nonaccredited hospitals. During fiscal year 1989, HCFA conducted a limited number of surveys in nonaccredited general acute-care hospitals previously surveyed by state agencies. The purpose of these surveys was to assess the effectiveness of the agencies' efforts to identify hospitals that are out of compliance with Medicare conditions of participation. HCFA found that 25 percent of the state agency surveys did not identify all conditions of participation that were out of compliance. The failure of state agencies to identify these problems could be indicative of any number of problems, such as insufficient training, too little time to perform adequate surveys, or limited expertise of the surveyors. More importantly, the overall reliability of state agency surveys becomes questionable. HCFA regional offices involved in these surveys did not know what caused the differences in the survey findings, nor did they take action to prevent them from recurring.

Joint Commission Survey Data Can Be Used to Track Follow-Up Efforts but Not to Identify Medicare Conditions That Are Out of Compliance

In theory, complete access to Joint Commission data should help HCFA to determine whether significant deficiencies relating to Medicare conditions of participation are being identified and corrected. In reality, this is not the case. Joint Commission data can be used by HCFA to track the timeliness of Commission efforts to achieve problem resolution in hospitals that are conditionally accredited or received accreditation with Type I recommendations. Thus, HCFA will have some knowledge about the timeliness of the Joint Commission's efforts to assure that corrective action is taken in hospitals that are out of compliance with its standards. But the data cannot be used by HCFA to identify hospitals that are out of compliance with Medicare conditions of participation because Joint Commission survey reports do not indicate how Commission findings presently correlate with Medicare conditions.

In 1987 and 1988, the Joint Commission encountered a severe backlog of survey reports and did not take timely follow-up action to assure that

hospitals corrected identified problems. Because of its lack of access to Joint Commission data, HCFA was unaware of the ramifications of this situation. For example, several deficiencies identified by the Joint Commission in 44 hospitals given conditional accreditation between July 1989 and June 1990 had been outstanding since 1986. In 15 of these hospitals, problems identified in 1986 were administratively cleared in 1988 with no corrective action taken. An additional 14 were cleared in 1989. Because of the backlog of surveys at the Joint Commission, its accreditation committee did not insist that corrective action be taken and deferred any further effort until the next scheduled survey. Thus, some of these hospitals continued in a state of noncompliance for at least 3 years after the problems were identified. HCFA was not aware of this particular situation, and it is unknown whether these hospitals were also out of compliance with Medicare conditions of participation. But the director of HCFA's Health Standards and Quality Bureau told us that the chances are very good that a hospital that receives a conditional accreditation from the Commission is out of compliance with one or more of Medicare's conditions of participation.

In June 1990 testimony before the Subcommittee on Health, House Committee on Ways and Means, the Joint Commission acknowledged that a

> "massive backlog of survey reports slowed the resolution effort. . .. During 1987 and 1988, many routine reports were not provided to hospitals until almost a year following [the] survey. For the more complex reports associated with problematic hospitals, the delays were often more extended."

The director of HCFA's Health Standards and Quality Bureau believes that the Joint Commission's time frame to achieve corrective action is inconsistent with Medicare's enforcement program and should be shortened. In May 1990, he wrote to the Joint Commission expressing concern about the length of time that the Joint Commission allows for conditionally accredited hospitals to correct deficiencies. Specifically, the director stated that the Joint Commission's process takes (1) 6 months from the date of the survey to when the hospital is notified of the problems, (2) an additional 3 months to approve the hospital's plan of correction, and (3) 6 more months before conducting an on-site survey to evaluate the adequacy of the hospital's corrective actions.

On November 27, 1990, the director again wrote to the Joint Commission and strongly recommended that it develop the capability to determine, within 10-14 days after the conclusion of an on-site survey, the seriousness of the deficiencies identified and the timetable on which corrective

action should be required (e.g., within 30 days, 90 days, or 1 year). He also stated that it is critical that the Joint Commission quickly develop such a system together with the follow-up capability to assure that identified deficiencies are corrected within the time frames outlined.

On March 4, 1991, the Commission told HCFA that it has the capability to determine, within 10-14 days after the conclusion of an on-site survey, the seriousness of a deficiency and the timetable on which it should be corrected. The Commission also stated that because of the complexity of some survey findings and due process provisions, close to 60 days may pass before a decision is made and a hospital notified that it will receive a conditional accreditation or be denied accreditation. The Commission considers the 60-day time frame unacceptable and suggested that several options be discussed for earlier transmittal of relevant information to HCFA. For example, the Commission stated that it could notify HCFA of all recommendations for preliminary conditional accreditation or denial of accreditation at the same time that such preliminary notice is provided to affected hospitals.

In February 1991, the Commission told us that by the end of 1990, the turnaround time from the point at which a survey is complete to the time a hospital is notified that it will receive a Type I recommendation had, on average, been reduced to less than 60 days. The Commission made no reference to the amount of time it takes to approve a hospital's plan of corrective action or conduct on-site surveys to evaluate the adequacy of the hospital's corrective action. But, if the Joint Commission provides HCFA with complete and timely access to Commission survey data, HCFA will be able to track Commission efforts to follow up on identified deficiencies to determine if corrective actions have been taken in a timely manner. Thus, situations similar to those that occurred with the conditionally accredited hospitals between 1986 and 1989 should be identifiable to HCFA.

Until an effective crosswalk is established, however, HCFA will not know whether accredited hospitals that are out of compliance with one or more Joint Commission standards are also out of compliance with Medicare conditions of participation. As we discussed in our June 1990 report and cited in June 1990 testimony, Joint Commission survey reports do not relate their findings to Medicare conditions of participation, and HCFA does not have an accurate method to compare the two

sets of requirements to determine the effectiveness of the Joint Commission's process. In that report we recommended that a means be established through which existing Medicare conditions and Joint Commission standards can be effectively compared.

In March 1990, HCFA prepared a draft crosswalk comparing Medicare conditions of participation with the Joint Commission's 1988 Accreditation Manual for Hospitals and requested the Commission to examine it for accuracy. The Joint Commission complied with this request in June 1990 and told HCFA that the crosswalk may represent only the first stage of a more complex process. The Commission further stated that both organizations need to have a better understanding of how Medicare conditions and Commission standards are actually applied in the parallel survey processes. On February 20, 1991, the Joint Commission provided HCFA and us with a comprehensive draft crosswalk of HCFA's conditions of participation and the Joint Commission's 1990 hospital standards. The Commission requested HCFA to review the crosswalk and verify its accuracy. The Commission also requested HCFA to indicate whether a deficiency in a Commission standard would have a high, medium, or low impact on the overall compliance with a related Medicare condition of participation.

The Commission has established the relative importance (e.g., weight) of each required characteristic and element in its standards, and uses detailed algorithms (e.g., mathematical computational processes) to score the survey results. This system consistently relates a hospital's compliance with individual standards to performance scores that form the basis for Type I recommendations and the ultimate accreditation decision. Conversely, HCFA has not weighted the standards and elements that comprise Medicare conditions of participation. Thus, the Commission is concerned that the two organizations may interpret survey findings in a different manner.

In March 1991, the Commission told HCFA's director, Health Standards and Quality Bureau, that in order to directly relate degrees of noncompliance with Joint Commission standards to the standards that underlie the Medicare conditions of participation, it is critically important that HCFA develop algorithms that weight its standards and relate them to the Medicare conditions of participation. The Commission also stated that this task is integral to the completion of the crosswalk project and expressed a willingness to work with HCFA in the design of appropriate algorithms. The Commission concluded, however, that only HCFA can

determine the relative significance and importance of specific Medicare standards.

HCFA Needs to Monitor State Agency Survey Efforts More Closely

HCFA regional offices do not routinely verify state agency survey findings to determine how well these agencies are evaluating compliance with Medicare conditions of participation in nonaccredited hospitals. But when monitoring surveys are conducted to assess the effectiveness of the state agency efforts, a significant number show that state agencies are not identifying all hospitals that are out of compliance with one or more Medicare conditions of participation. Further, in their selection of hospitals to be surveyed, some state agencies are not giving priority attention to hospitals that, in prior years, have had difficulty adhering to Medicare conditions of participation. As a result, state agencies could be allowing nonaccredited hospitals that are out of compliance with Medicare conditions of participation to continue to provide health care to Medicare beneficiaries.

HCFA Monitoring Surveys Detect Differences in Survey Findings but Should Be Conducted More Often

HCFA monitoring surveys in nonaccredited acute-care hospitals often detect significant differences between the findings of HCFA and the state agency surveyors. But the number of monitoring surveys that are conducted is limited. HCFA's central office establishes a minimum number of monitoring surveys that are to be conducted annually by its regional offices and provides funds to accomplish them. Except for long-term care facilities—for which the Congress required a 5-percent minimum annual monitoring sample—HCFA does not have an established number of surveys that the regions must perform in any given provider group (e.g., home health agencies, laboratories, end-stage renal disease providers, and nonaccredited acute-care hospitals). As a result, some regional offices do not verify the state agency survey results in nonaccredited hospitals on a large scale, despite the fact that relatively high numbers of discrepancies are found between the findings of HCFA and the state agencies when such verification is done.

In fiscal year 1989, 6 of 10 HCFA regional offices conducted 32 comparative monitoring surveys to assess the accuracy of the 890 state agency surveys of nonaccredited hospitals. The remaining 4 regions, in which 151 nonaccredited hospitals were surveyed by cognizant agencies in 22 states/territories, did not perform any monitoring surveys. Of the 32 monitoring surveys conducted, federal survey teams found 8 instances where state agencies failed to detect that certain Medicare conditions of participation were not being complied with. In one hospital where no

conditions of participation were found to be out of compliance by the state agency, HCFA surveyors found that Medicare conditions involving infection control, quality assurance, and medical staff were all out of compliance. Shortly thereafter, HCFA initiated termination action against the hospital on the basis of its findings.[6] HCFA surveyors in another region found five hospitals to be out of compliance with the laboratory condition of participation. State surveyors did not detect the problem in any of these facilities. Further, HCFA regional offices involved in these surveys could not tell us why the differences occurred, nor did they take action to prevent them from recurring. Table 1 shows the number of surveys conducted in each region in fiscal year 1989, the number of times any of these surveys were evaluated by HCFA for accuracy, and the results of these evaluations.

[6]HCFA procedures call for termination action against hospitals that do not comply with Medicare conditions of participation.

Table 1: Comparative Federal Monitoring Surveys Conducted in Fiscal Year 1989

Region	Nonaccredited hospital surveys	Monitoring surveys	Findings
I	4	•	
II	30	•	
III	16	•	
IV	208	4	Concurred with state findings in all four hospitals.
V	101	•	
VI	251	8	Concurred with state findings in three hospitals; HCFA found five hospitals with laboratory condition of participation out of compliance that state agencies did not detect.
VII	207	7	Concurred with state findings in six hospitals; HCFA found one hospital with quality assurance, medical staff, and infection control conditions of participation out of compliance that state agency did not detect.
VIII	119	6	Concurred with state findings in five hospitals; HCFA found one hospital with quality assurance and laboratory conditions of participation out of compliance that state agency did not detect.
IX	32	3	Concurred with state findings in two hospitals; HCFA found one hospital with governing body, quality assurance, nursing and medical staff conditions of participation out of compliance that state agency did not detect.
X	73	4	Concurred with state findings in all four hospitals.
Total	**1,041**	**32**	

Selection of Hospitals to Be Surveyed Does Not Focus on Those With Potential for Quality-of-Care Problems

State agencies do not always place a priority on conducting surveys in nonaccredited hospitals that have a high potential for being out of compliance with Medicare conditions of participation. As a result, hospitals that have a history of noncompliance are not always surveyed annually. For example, in the five regions we visited, 12 of the 14 hospitals found out of compliance with Medicare conditions of participation in fiscal year 1987 were not surveyed in 1988. In fiscal year 1989, only 3 of the 12 hospitals were surveyed, and each was again out of compliance.

Depending on the funding available, HCFA expects state agencies to annually survey at least 75 percent of the nonaccredited general acute-care

hospitals in their jurisdictions. Our review showed that state agencies generally meet this objective. (See app. III.) HCFA also encourages state agencies to survey hospitals that have trouble complying with Medicare conditions of participation. But state agencies are allowed to use their own discretion in the selection of hospitals to be surveyed.

Conclusions

To effectively assess the Commission's ability to identify hospitals that are not complying with Medicare requirements, HCFA must be able to establish a direct relationship between its conditions of participation and the Commission's standards. The two organizations are working together to achieve this goal. Once it is accomplished, HCFA will have the capacity to accurately match the standards and elements that comprise its Medicare conditions to the required characteristics and elements that comprise Commission standards. Since HCFA accepts Joint Commission accreditation of a hospital as evidence that it meets Medicare conditions of participation, we believe that the Joint Commission has a responsibility to assure that Medicare conditions are complied with. We also believe that the Commission should use the crosswalk data and annotate its survey reports to clearly identify any of its requirements that are not being complied with that have related Medicare requirements. This is a relatively simple matching process that will identify problem areas that involve Medicare standards and elements. HCFA analysts can then use the Commission survey reports to make a final determination as to whether a Medicare condition is being complied with. HCFA would still, however, need to validate the Joint Commission's survey efforts.

Joint Commission survey reports that are annotated to identify deficiencies having applicability to Medicare requirements can benefit HCFA in at least two ways. First, state agency validation survey findings and Commission accreditation survey findings can be easily compared. Second, HCFA can use the annotated Commission reports to identify hospitals that may be having trouble meeting Medicare conditions and can track the Commission's follow-up efforts to assure itself that all problems relating to Medicare requirements are corrected. Thus, once a crosswalk is agreed upon, HCFA should arrange for the Joint Commission to provide timely survey information on every Type I recommendation that the Commission finds to be related to a Medicare requirement. HCFA will then be aware of all hospitals the Joint Commission has identified as having deficiencies in areas involving Medicare requirements. Depending on how serious HCFA analysts believe the problem to be and how timely the Joint Commission follow-up is taken, HCFA can either

monitor Commission follow-up efforts to assure that corrective actions are taken or intercede to assure that timely corrective action is taken.

While a mutually acceptable crosswalk between Medicare and Commission requirements is being developed, HCFA can make better use of Joint Commission survey findings. Although Commission reports do not specify compliance or noncompliance with conditions of participation, standards, or elements, the chances are good that a hospital that is conditionally accredited is out of compliance with one or more Medicare requirements. Thus, HCFA should utilize the survey data currently available from the Commission to identify conditionally accredited hospitals and monitor the Commission's follow-up efforts to assure that corrective action is taken in a timely manner.

In addition to its survey responsibilities with respect to accredited hospitals, HCFA must also assure that state agencies accurately assess how well nonaccredited hospitals meet Medicare conditions of participation. To do this effectively, HCFA should (1) require its regional offices to conduct a sufficient number of monitoring surveys to assess the accuracy of state agencies' efforts in general acute-care hospitals and (2) take appropriate action to decrease recurring differences between HCFA and state agency survey findings. We recognize that there are competing demands placed on HCFA to monitor long-term care facilities and other provider groups. But the relatively high number of instances in which state agency surveyors failed to identify hospitals that are out of compliance with Medicare conditions of participation could be an indication that serious problems exist in some state agencies' survey processes.

HCFA regional offices should also assure that state agencies regularly survey hospitals that have a history of noncompliance with Medicare conditions of participation.

Recommendations

We recommend that the Secretary of HHS direct HCFA's Administrator to:

- Continue to work with the Joint Commission to develop a crosswalk between Medicare conditions and Commission standards. Once the crosswalk is completed to the satisfaction of HCFA and the Commission, HCFA should request the Commission to annotate its survey reports to identify standards, required characteristics, and elements that are not being complied with that relate to specific Medicare requirements.
- Closely monitor the Joint Commission's follow-up of hospital efforts to correct deficiencies that it has found to relate to Medicare conditions of

participation and, where necessary, intercede to assure that the hospital takes timely corrective action. This includes conditionally accredited hospitals and those receiving an accreditation with Type I recommendations.

- Establish a minimum number or percentage of monitoring surveys that must be conducted by federal personnel in nonaccredited hospitals and follow up on the causes of any differences that are identified between federal and state agency survey findings.
- Develop survey guidance that requires priority attention be given to hospitals with a history of noncompliance with Medicare requirements when determining which nonaccredited hospitals to survey.

Agency Comments

In a February 27, 1991, letter, HHS stated that it is in substantial agreement with our recommendations and expects to implement them. (See app. IV.) HHS believes, however, that we place too much emphasis on the crosswalk. HCFA has a crosswalk that it is updating and believes that it is sufficient to determine the comparability of HCFA and Commission survey findings. In HHS's opinion, the real issue is the comparability between the Commission's entire accreditation process and Medicare's certification process. HHS is particularly concerned about the amount of time it takes the Joint Commission to make a decision on survey findings, inform hospitals of the problems identified, and ensure that action is taken within time frames comparable to HCFA's processes under Medicare.

We agree that it is important for the Joint Commission to take timely action to notify hospitals that problems exist and follow up to assure that corrective action is taken. But we disagree with the HHS statement that too much emphasis is placed on the crosswalk and that the current crosswalk is sufficient for HCFA's needs. In our opinion, an effective crosswalk is fundamental to any efforts to assure that the Commission is identifying Medicare standards and elements that are not being complied with. Further, the current HCFA crosswalk cannot perform this function.

HHS also stated that on December 14, 1990, a proposed regulation was published entitled Medicare Program; Granting and Withdrawal of Deeming Authority to National Accreditation Organizations. This regulation is intended to expand the types of providers and suppliers of services that HHS may consider or "deem" to meet conditions of participation, certification, or conditions of coverage by virtue of their accreditation by a national accreditation program.

In appendix I of this report we cite several conditions that we believe must be met before the Joint Commission or any other organization is given "deemed" status in areas other than acute-care hospitals (see p. 24). These conditions essentially involve assuring that there is a clear and definable relationship between the survey requirements of the federal government and the accrediting organization, that an accurate assessment can be made of the accrediting organization's performance in assuring that federal requirements are being met, and that the requirements of both entities are periodically updated to assure that they are compatible and apply to current conditions. The proposed regulation is silent on updating an accrediting organization's requirements. However, it adequately covers all of the remaining conditions that we believe are important.

In technical comments on this report, HCFA stated that in fiscal year 1991, state agencies will be instructed to survey 100 percent of the nonaccredited general acute-care hospitals in their jurisdictions. This will satisfy our recommendation that priority attention be given to hospitals with a history of noncompliance with Medicare requirements when determining which nonaccredited hospitals to survey.

HCFA also stated that in fiscal year 1991, it will perform federal monitoring surveys for a 2-percent sample of nonaccredited hospitals and other provider types. However, no mention was made about follow-up action on problems identified. Given the problems that were detected from a 3-percent sample of nonaccredited hospitals in 1989 (see table 1, p. 11), we believe that a reduction in the sample size to 2 percent in 1991 is inappropriate. Further, HCFA should stipulate that all regional offices must conduct sample surveys to determine whether the state survey agencies within their jurisdictions are identifying all Medicare conditions of participation that are out of compliance.

Joint Commission Comments

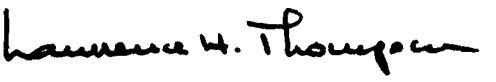
In a letter dated February 4, 1991, the Joint Commission stated that the report generally provides a thorough and accurate representation of the subject matter. But the Commission also stated that before it can use its accreditation survey results to determine which Medicare conditions of participation are not being complied with, HCFA must establish the relative importance of each standard and element that comprises a Medicare condition of participation. These data can then be applied to related Joint Commission required characteristics and elements, and, using a detailed set of algorithms, the Commission can decide whether a given Medicare condition is out of compliance. Further, the Commission

believes that HCFA needs such a system to consistently relate the standards that underlie the Medicare conditions of participation to individual conditions.

The Commission also believes that the Medicare conditions of participation should be updated, and it referred to a 1990 Institute of Medicine (IOM) report, Medicare: A Strategy for Quality Assurance, which addresses the need for such an update. In this report, IOM stated that the 1986 revisions to the Medicare conditions of participation are largely based on work done in the late 1970s and early 1980s and resemble the evolution of the Joint Commission standards during that period. IOM concluded that the Joint Commission's standards have undergone substantial evolution since the early 1980s with no corresponding change in the Medicare conditions.

In a draft of this report, we recommended that HCFA require the Joint Commission to incorporate data in its survey reports to specifically identify Medicare conditions of participation that are not being complied with. However, in the final report we modified this recommendation to reflect the Commission's belief that it cannot make decisions about compliance because HCFA has no system for weighting the relative importance of the standards and elements that comprise Medicare conditions of participation. Whether the relative importance of the standards and elements that comprise a Medicare condition of participation should be established or the Medicare conditions of participation revised to assure that they have applicability to the current medical environment will be the subject of a follow-on review by us. It should be recognized, however, that if HCFA positively responds to the February 1991 request of the Joint Commission (see p. 8) to review the crosswalk and indicate whether a deficiency in a Commission standard would have a high, medium, or low impact on the overall compliance with a related Medicare condition of participation, the weighting process sought by the Commission will have already begun.

Copies of this report are being sent to appropriate congressional committees; the Secretary of Health and Human Services; the Director, Office of Management and Budget; and other interested parties. This report was prepared under the direction of David P. Baine, Director, Federal Health Care Delivery Issues, who may be reached on (202) 275-6207 if you have any questions about this report. Other major contributors are listed in appendix V.



Lawrence H. Thompson
Assistant Comptroller General

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Abbreviations

HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
IOM	Institute of Medicine
QHR	Quality Healthcare Resources, Inc.

Responses to Questions Raised by Congressional Requesters

Our review of efforts made by the Joint Commission and the Health Care Financing Administration to assure that hospitals serving Medicare patients provide quality care addressed the following questions from Representative Fortney H. (Pete) Stark, Chairman, Subcommittee on Health, House Committee on Ways and Means, in his November 2, 1988, letter, and Senator Dave Durenberger in his letter of January 2, 1989.

1. Does the Joint Commission's insistence on confidentiality of review findings interfere with the goal of protecting beneficiaries from poor quality?

2. Does the fact that the Joint Commission sells advice to hospitals on how to pass its inspections appear to affect the findings in Joint Commission surveys?

3. Has HCFA monitored hospital surveys sufficiently to make a judgment about the likely impact of a policy that would extend "deemed status" to other types of facilities?[1] Are there any additional safeguards GAO would recommend if the Congress adopted this policy?

4. Are there other appropriate alternatives to the existing system of Joint Commission surveys backed up by state validation surveys that the Congress should consider?

5. What risks and benefits attend any possible changes in federal recognition of voluntary accreditation initiatives?

6. What are the additional federal resource requirements of the reduction or cessation of recognition of accreditation of hospitals by voluntary organizations (e.g., Joint Commission) for purposes of Medicare certification?

Summary

With the passage of Public Law 101-239 the confidentiality of Joint Commission survey findings is no longer an issue. Further, the selling of advice on how to pass inspections does not appear to affect the findings of Joint Commission survey teams. Alternatives are available to the present system of Joint Commission surveys backed up by state agency surveys, but none are clearly superior to the present system if it is functioning well.

[1]Deemed status means that HCFA accepts Joint Commission accreditation as evidence that a facility meets Medicare standards.

HCFA has not monitored the Joint Commission's survey efforts effectively enough to make a judgment as to whether "deemed status" should be extended to other types of facilities. If, however, the Joint Commission or any other organization is given deemed status in other areas, several safeguards should be taken to assure that Medicare beneficiaries are protected.

If the Joint Commission is taken out of the process and replaced by either HCFA, state agency, or private-sector surveys, additional personnel would have to be hired and a significant ongoing effort would have to be conducted to assure consistency in the conduct of the surveys, interpretation of survey results, and the training of the survey teams. HCFA estimates that if it took over this function, the costs and staffing needs would be extensive.

Confidentiality of Joint Commission Survey Data Is No Longer an Issue

Section 6019 of Public Law 101-239, enacted on December 19, 1989, requires the Joint Commission to provide the Department of Health and Human Services with any information directly related to its accreditation surveys that the Secretary of HHS may require—including hospital corrective action plans. This provision became effective on June 19, 1990, and should effectively eliminate any problems that the confidentiality of Joint Commission data created for HCFA in its efforts to assess the effectiveness of the Joint Commission's survey process. But as we have stated repeatedly, HCFA must be able to identify its conditions of participation in the Joint Commission standards before it can effectively use the Joint Commission data now available to it.

Acquiring Joint Commission Education Services Does Not Guarantee Accreditation

The Joint Commission provides, on a fee basis, a variety of resources and services to health care providers to assist them in interpreting and implementing Commission standards. The Commission believes that recipients will benefit from the information obtained and will use it to enhance their organization's ability to meet applicable standards. But there is no indication that acquiring these services will influence or "buy" accreditation from the Joint Commission. In fact, the Commission includes a statement in most of its educational publications and advertisements that acquiring such services will have no impact on its accreditation decisions.

The Joint Commission's Division of Education includes three departments: the Departments of Publications, Education Programs, and Educational Resources. Each department provides information and support

services to health care providers. These services consist of books, periodicals, audiovisual materials, live interactive video conferences, television programming, national and international conferences, and educational programs. In addition, the Joint Commission offers regional presurvey conferences to hospitals through state and local hospital associations and maintains a speaker's bureau.

In 1987, the Joint Commission established a not-for-profit subsidiary corporation called Quality Healthcare Resources, Inc. (QHR), to provide technical educational assistance to organizations interested in improving the effectiveness of their quality-assurance activities and meeting other health care standards. While the senior officials in QHR also hold high level positions in the Joint Commission, internal controls pertaining to conflict of interest and confidentiality of QHR data have been established to help assure that acquisition of QHR consulting services does not impact on the Joint Commission's accreditation decisions.

We were unable to determine the effectiveness of a key internal control that prohibits QHR consultants and staff from participating in Joint Commission meetings in which accreditation survey findings on a QHR client are expected to take place. Minutes of Joint Commission Accreditation Committee meetings were not sufficiently detailed to determine whether QHR personnel excused themselves from such meetings. Joint Commission attorneys did, however, provide us with documentation indicating that from 1987 to the present, two hospitals that acquired technical educational assistance from QHR had been given either a tentative nonaccreditation or a conditional accreditation by the Joint Commission.

Another QHR internal control prohibits dissemination of QHR data to Commission surveyors. To determine the effectiveness of this control we interviewed several Joint Commission surveyors to determine what information they were provided before each accreditation survey was initiated. Every surveyor stated that they do not solicit information about a hospital's acquisition of technical educational data, if any, from the Joint Commission. Further, in their opinion, provision of such information would have had no bearing on their professional judgment and reporting of survey findings.

HCFA's Survey Process Cannot Determine the Impact of Extending Deemed Status to Other Types of Facilities

HCFA cannot accurately assess the effectiveness of the Joint Commission's accreditation process in acute-care hospitals. A detailed discussion of why HCFA cannot make this assessment is contained in our June 1990 report and testimony. Because of its limited knowledge of the effectiveness of the Joint Commission's accreditation efforts, HCFA is in no position to judge what the impact would be if deemed status were granted to the Joint Commission in other types of facilities. But in December 1990, HHS published a proposed regulation entitled Medicare Program: Granting and Withdrawal of Deeming Authority to National Accreditation Organizations. This new regulation will permit HCFA to deem entities other than hospitals to meet the conditions of participation or certification or conditions for coverage, if HCFA finds that a national accreditation organization has provided reasonable assurance that these conditions are met.

Under this proposed regulation, a new section will be added to the Code of Federal Regulations (42 C.F.R. 488.9) that governs HHS's review of accrediting bodies. Specifically, HHS will examine:

- an accrediting organization's accreditation requirements to determine whether they are equivalent to those of HHS;
- the accrediting organization's survey process to determine the composition of the survey team, its qualifications, and its ability to continue surveyor training;
- the comparability of HHS's and the accrediting organization's survey procedures;
- the accrediting organization's monitoring procedures for providers or suppliers found out of compliance;
- the ability of the accrediting organization to provide HCFA with electronic data and reports necessary for effective validation and assessment of the survey process;
- the adequacy of the accrediting organization's staff and other resources; and
- the accrediting organization's ability to provide adequate resources for performing required surveys.

Criteria and procedures for removing the deeming authority of an accrediting organization have also been established under this regulation. Specifically, if HHS finds that an accrediting organization has a disparity rate of 20 percent or more between its accreditation determinations and the determinations of a state survey agency, or if

validation survey results over a period of 2 or more years show a pattern of increasing disparity between the determinations of an accrediting organization and the state agency, HHS will conduct a deeming authority review.

During such a review, HHS will reevaluate whether the accrediting organization meets all applicable criteria. If HHS finds that the organization's requirements are not comparable with the government requirements, it may place the organization on probation for a period of up to 180 days to adopt comparable requirements. If the accrediting organization has made no significant improvements during the probationary period, HHS will remove recognition of deemed authority, effective 30 days after written notice has been provided to the accrediting organization.

Although HCFA cannot use its current experience to make projections about the effectiveness of the Joint Commission's accreditation process if it was extended to other facilities, certain preconditions are needed before the Joint Commission or any other organization is given deemed status in other areas. Specifically, there must be a clear and definable relationship between federal requirements and the standards of the accrediting organization, a validation system must be established that will allow an accurate assessment to be made of the accrediting organization's performance in assuring that federal requirements are being met, and the requirements of both entities must be examined and updated periodically to assure that they are compatible and apply tc current conditions. With the exception of periodically updating the requirements of both the accrediting body and HCFA to assure that the requirements apply to current conditions, the proposed regulation meets all of the evaluation criteria that we believe to be important.

Alternatives to the Joint Commission Should Be Considered Only If the Present System Cannot Be Made More Effective

Alternatives to the present system of relying on the Joint Commission to assure that quality care is provided to Medicare patients in acute-care hospitals are available. However, none are clearly superior to the current system if it was operating effectively. Alternatives include (1) establishing an organization within HCFA that would allow hospital surveys to be conducted by HCFA staff assigned to either the central office or the regions, (2) expanding the role of state agencies in the survey process, and (3) allowing private organizations other than the Joint Commission to perform surveys of hospitals serving Medicare patients.

The Joint Commission has been in the business of surveying and accrediting hospitals for over 39 years. Its certificate of accreditation is generally accepted by the medical community as evidence that a hospital is capable of providing quality health care. Over the years, the Joint Commission has developed an assessment expertise that is not available elsewhere. Further, it has controls built into its accreditation procedures that are designed to assure that hospitals receive a complete and accurate assessment of their quality assurance processes. HCFA now has access to all Joint Commission survey data and can examine whatever information it chooses. But, as previously stated, the information will not be effectively utilized until the Joint Commission and HCFA develop a system to directly relate their requirements and incorporate this information in Joint Commission survey reports. Until this is done, HCFA will not have reasonable assurance through the accreditation system that hospitals are complying with its Medicare conditions of participation.

HCFA estimates that it would cost $59 million and require 722 full-time employees to perform annual surveys of the more than 5,000 hospitals that serve Medicare patients. In addition, HCFA would have to (1) establish an organizational structure to perform this new function; (2) hire, train, and maintain a staff of professionals in job categories (e.g., physicians and nurses) that are in scarce supply; and (3) hire additional attorneys to handle due process considerations. HCFA would also have to fully absorb the cost of this effort. Under the provisions of Public Law 101-508, the Omnibus Budget Reconciliation Act of 1990, user fees for survey and certification purposes are prohibited.

The primary advantage of such an alternative would be that HCFA would know immediately after an inspection when a hospital is out of compliance with Medicare conditions of participation and could take prompt action to assure that any problems are corrected.

A second alternative would be to expand the role of state agencies in the survey process. The cost of this option would be about the same as maintaining an in-house work force in HCFA. But HCFA would be required to pay much greater attention than it now does to assure that state agencies are effectively assessing the quality of care provided in these hospitals. Further, mechanisms to assure that hospitals receive due process on adverse findings would have to be expanded. The benefit of such a system is that it is already established and would only require an increase of trained state survey teams.

A third alternative would be to allow private organizations, other than the Joint Commission (e.g., management and consulting firms with a health care interest) to conduct the surveys under contract with HCFA. This option could be expensive, and HCFA would have to closely monitor the quality and consistency of their survey efforts. Further, in order to develop expertise in the area, these organizations would have to hire, train, and maintain a cadre of survey teams to perform this work. HCFA's experience with private contractors performing surveys in psychiatric hospitals serving Medicare patients illustrates this point. Specifically, in fiscal year 1989, HCFA contracted with various private organizations throughout the nation to perform 450 surveys in psychiatric hospitals serving Medicare patients. The cost of this effort was about $3 million—an average of about $7,000 per survey. But the scope of work involved only 2 special psychiatric conditions of participation, whereas HCFA has 20 conditions of participation that it tracks in acute-care hospitals. HCFA also has 13 staff in its central office and various regions to monitor contractors' survey efforts. As with the first two options, the primary benefit would be that HCFA would receive immediate notice that a hospital is out of compliance with Medicare conditions of participation. HCFA would still, however, be required to monitor the performance of any such organization.

Scope and Methodology

In performing this review, we visited the Joint Commission, HCFA's central office and 5 of its 10 regional offices,[1] and six state agencies that perform surveys for HCFA. Our work focused on each organization's interaction with general acute-care hospitals because they are the only type of facilities for which HCFA relies on the Joint Commission to determine compliance with Medicare conditions of participation. We conducted our evaluation between August 1989 and July 1990 in accordance with generally accepted government auditing standards.

At the Joint Commission we talked with officials and reviewed pertinent documentation relating to the Joint Commission's survey policies and procedures, determined the extent to which the Joint Commission interacts with HCFA when problems in accredited hospitals are identified, discussed how surveyors are trained, and talked about how the Joint Commission maintains consistency in the survey process. We also interviewed eight Joint Commission surveyors to discuss their training, duties, and responsibilities and reviewed documentation relating to the relationship between the Joint Commission and its subsidiary company, QHR. This company provides consulting services to hospitals with respect to quality assurance activities. Finally, we examined case files for the 44 hospitals that were given a conditional accreditation by the Joint Commission between July 1, 1989, and June 1990. We then determined the time it took from problem identification to scheduled follow-up action in hospitals that the Commission considers to have serious quality-of-care problems.

At HCFA's central office we talked with officials and examined pertinent documentation regarding Medicare legislation; HCFA regulations and operating manuals; HCFA oversight and monitoring of its regions, the Joint Commission, and state survey agencies; and its plans to use the additional Joint Commission information available under Public Law 101-239. At HCFA's regional offices we interviewed officials and examined pertinent procedures for monitoring state agency surveys of nonaccredited and accredited hospitals. We then determined whether the regional offices and state survey agencies comply with HCFA central office procedures for follow-up and termination actions against hospitals that do not comply with Medicare conditions of participation. We reviewed 117 files on nonaccredited hospitals that HCFA had identified as being out of compliance with its conditions of participation from October 1986 to September 1989. At the state agencies in California, Colorado, Georgia, Tennessee, Illinois, and New York, we examined files

[1]We visited the regional offices in Georgia, California, Illinois, New York, and Colorado.

of accredited and nonaccredited hospitals to determine whether the state, during a licensing or other type of survey, had developed information on problems with these hospitals that was not available within HCFA. We also talked with state officials and reviewed pertinent information on the procedures each state follows in the conduct of HCFA surveys and the training each provides to the surveyors who perform these examinations.

We did not evaluate the actual surveys conducted by either the Joint Commission or state surveyors, nor did we assess the adequacy of Medicare conditions of participation and Joint Commission standards for determining a hospital's ability to provide quality health care.

State Agency Surveys Conducted in Nonaccredited Hospitals (1986-88)

State	Year	Number of nonaccredited hospitals	Number of nonaccredited hospitals surveyed	Percent surveyed
Region II				
New Jersey	1986	3	2	67
	1987	3	3	100
	1988	3	1	33
New York	1986	5	4	80
	1987	6	5	83
	1988	6	6	100
Puerto Rico	1986	25	25	100
	1987	26	20	77
	1988	27	27	100
Virgin Islands	1986	1	0	0
	1987	1	1	100
	1988	1	0	0
Subtotal		**107**	**94**	**88**
Region IV				
Alabama	1986	21	20	95
	1987	21	21	100
	1988	21	19	90
Florida	1986	34	24	71
	1987	34	28	82
	1988	34	25	74
Georgia	1986	56	52	93
	1987	56	53	95
	1988	56	46	82
Kentucky	1986	25	19	76
	1987	25	25	100
	1988	25	25	100
Mississippi	1986	54	51	94
	1987	54	44	81
	1988	54	54	100
North Carolina	1986	18	18	100
	1987	18	15	83
	1988	18	18	100
South Carolina	1986	12	9	75
	1987	12	12	100
	1988	12	11	92
Tennessee	1986	17	15	88
	1987	17	17	100
	1988	17	14	82
Subtotal		**711**	**635**	**89**

(continued)

State	Year	Number of nonaccredited hospitals	Number of nonaccredited hospitals surveyed	Percent surveyed
Region V				
Illinois	1986	19	11	58
	1987	15	11	73
	1988	18	12	67
Indiana	1986	35	21	60
	1987	34	22	65
	1988	27	23	85
Michigan	1986	16	6	38
	1987	12	7	58
	1988	9	7	78
Minnesota	1986	65	39	60
	1987	65	50	77
	1988	59	42	71
Wisconsin	1986	30	16	53
	1987	27	22	81
	1988	28	19	68
Ohio	1986	19	0	0
	1987	20	1	5
	1988	19	1	5
Subtotal		**517**	**310**	**60**
Region VIII				
Colorado	1986	23	17	74
	1987	23	11	48
	1988	23	15	65
Montana	1986	43	40	93
	1987	43	35	81
	1988	43	39	91
North Dakota	1986	31	24	77
	1987	31	27	87
	1988	31	26	84
South Dakota	1986	44	33	75
	1987	44	37	84
	1988	44	32	73
Utah	1986	19	16	84
	1987	19	16	84
	1988	19	13	68
Wyoming	1986	8	8	100
	1987	8	8	100
	1988	8	7	88
Subtotal		**504**	**404**	**80**
Total		**1,839**	**1,443**	**78**

Note: Region IX could not provide the universe of nonaccredited hospitals or the number of surveys that had been conducted.

Comments From the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES — Office of Inspector General

Washington, D.C. 20201

FEB 27 1991

Mr. David P. Baine
Director, Federal Health Care
Delivery Issues
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Baine:

Enclosed are the Department's comments on your draft report, "Health Care: Hospitals With Quality of Care Problems Need Closer Monitoring." The comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely yours,

For Richard P. Kusserow
Inspector General

Enclosure

Comments of the Department of Health and Human Services on the General Accounting Office Draft Report, "Health Care: Hospitals With Quality of Care Problems Need Closer Monitoring"

Overview

The Health Care Financing Administration (HCFA) considers hospitals that are out of compliance with one or more Medicare conditions of participation to be susceptible to providing poor quality care. However, according to GAO, HCFA has not been able to accurately determine whether hospitals accredited by the Joint Commission on Accreditation of Healthcare Organizations' (JCAHO) are complying with Medicare conditions of participation.

The Department notes that the report does not recognize the restructuring of the entire JCAHO monitoring process HCFA initiated over a year ago. We have totally revised the process to meet the need to monitor the full range of JCAHO's activities. This should be recognized in the report.

The Department further notes that GAO continues to place too much emphasis on the crosswalk. (Such a crosswalk defines the relationship between Medicare conditions of participation and JCAHO standards.) We already have a crosswalk and are working to update it. We continue to believe that while the new crosswalk will add precision to some of our comparisons, we can sufficiently determine the comparability of JCAHO's findings to ours. The real issue is the comparability of the entire accreditation process to Medicare's certification process. This is where the JCAHO is most deficient and where we have taken steps to improve our monitoring.

To further illustrate our intent for closer monitoring of JCAHO, American Osteopathic Association and any other organization approved by the Secretary, on December 14, 1990, we published a proposed regulation at 42 CFR Parts 401 and 488. The regulation is entitled "Medicare Program; Granting and Withdrawal of Deeming Authority to National Accreditation Organizations". This regulation proposes to implement section 1865(a) of the Social Security Act, as amended by sections 2345 and 2346 of Public Law 98-369 and section 6019 of Public Law 101-239. The amendments expand the types of providers and suppliers of services that we may consider to meet conditions of participation or certification or conditions for coverage by virtue of their accreditation by a national accreditation program. These providers and suppliers would also be subject to validation surveys.

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Finally, on November 27, 1990, the Director of HCFA's Health Standards and Quality Bureau wrote to the President of the JCAHO expressing HCFA's concerns that the JCAHO was not able to respond quickly and effectively to problems of substandard performance uncovered in on-site hospital surveys. Specifically, HCFA's concerns were directed toward the decision-making process at the JCAHO and the attendant capability necessary to inform hospitals about problems and ensure correction.

HCFA strongly recommended that the JCAHO develop the capability to determine, within 10-14 days after the conclusion of an on-site survey, whether a hospital fits into one of the following categories:

- o problems of sufficient seriousness to merit at least some specific correction within 30 days (e.g., pose a serious and immediate threat to patient health and safety);
- o problems of sufficient seriousness to merit at least some specific correction within 90 days; and
- o problems which must be corrected within 1 year.

HCFA noted that it believes it is critical that the JCAHO quickly develop such a system with the follow-up capability to ensure correction within the time frames outlined. HCFA concluded that it remains extremely concerned about the JCAHO's capability to notify hospitals about problems and ensure correction or loss of accreditation with time frames comparable to HCFA's processes under Medicare.

The letter provides additional support of the seriousness with which HCFA is pursuing its oversight responsibilities.

GAO Recommendations

We recommend that the Secretary of Health and Human Services direct HCFA's Administrator to:

- -- Continue to work with the Joint Commission to develop a crosswalk between Medicare conditions and Commission standards. Once the crosswalk is completed to the satisfaction of HCFA and the Joint Commission, HCFA

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should require the Joint Commission to incorporate data in its survey reports specifying hospitals' compliance or non-compliance with Medicare conditions of participation.

- Closely monitor the Joint Commission's follow-up of hospital efforts to correct deficiencies that it has found to relate to Medicare conditions of participation and, where necessary, intercede to ensure that timely corrective action is taken. This includes conditionally accredited hospitals and those receiving an accreditation with Type I recommendations.

- Establish a minimum number or percentage of monitoring surveys that must be conducted by Federal personnel in nonaccredited hospitals and follow-up on the causes of any differences between Federal and State agency survey findings that are identified.

- Develop survey guidance that requires priority attention be given to hospitals with a history of noncompliance with Medicare requirements when determining which nonaccredited hospitals to survey.

Department Comment

We are in substantial agreement with all of GAO's recommendations. We are concerned, however, that there is inadequate recognition of the fact that, as GAO is well aware, work has been underway for some time to implement these and further measures to ensure that HCFA maintains adequate oversight of JCAHO and that JCAHO performs its functions appropriately.

Both our current and planned efforts contemplate implementation of GAO's recommendations.

Technical Comments

HCFA has already provided GAO with a mark-up of the report to correct technical errors.

Major Contributors to This Report

Human Resources Division, Washington, D.C.	James A. Carlan, Assistant Director, (202) 708-4228 Michelle L. Roman, Assignment Manager Mary Ann Curran, Evaluator-in-Charge Suzanne Feiler, Evaluator Janice Raynor, Evaluator
New York Regional Office (Albany Sublocation)	John Ripper, Senior Evaluator Glenn H. Richter, Evaluator
Los Angeles Regional Office	Kathleen H. Ebert, Senior Evaluator Shawnalynn R. Smith, Evaluator

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