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United States Government Accountability Office
Washington, DC 20548

November 30, 2010

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

Subject: *Long-Term Care Hospitals: Differences in Their Oversight Compared to Other Types of Hospitals and Nursing Homes*

This report formally transmits our briefing slides highlighting differences in the oversight of long-term care hospitals (LTCH), other types of hospitals, and nursing homes (see enc. I). The slides are a partial response to your request letter and were used to brief your staff on November 29, 2010. We provided a draft of this report to the Department of Health and Human Services (HHS) and to The Joint Commission (TJC)—an accrediting organization that oversees the majority of LTCHs. HHS's comments, which indicated that the briefing slides were a welcome resource, are reproduced in appendix III of the slides. We also received technical comments from HHS and TJC, which we incorporated as appropriate.

We will address your questions about the types of quality and patient safety information collected on LTCHs by the Centers for Medicare & Medicaid Services (CMS) and the coordination among oversight organizations in a subsequent report.

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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 of this report to the Secretary of HHS, the Administrator of CMS, and relevant congressional committees. In addition, the report will be available at no charge on the GAO Website at http://www.gao.gov.

If you or your staffs have any questions regarding this report, please contact me at (202) 512-7114 or kohnl@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Key contributors to this report were Walter Ochinko, Assistant Director; Sarah Harvey; Kristin Helfer Koester; Elizabeth T. Morrison; Phillip J. Stadler; and Jennifer Whitworth.

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Enclosure

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Long-Term Care Hospitals: Differences in Their Oversight Compared to Other Types of Hospitals and Nursing Homes

Briefing for Staff of

Committee on Finance
United States Senate

November 29, 2010

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Overview

- Introduction
- Objective
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- Background
- Results
- Summary of Differences in Oversight among LTCHs, Other Hospitals, and Nursing Homes
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Overview

- Appendix I: CMS's 23 Hospital Conditions of Participation
- Appendix II: TJC's17 Categories of Hospital Standards
- Appendix III: Comments from HHS

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Introduction

- Long-term care hospitals (LTCH) provide acute and post acute care to clinically complex individuals who have multiple acute or chronic conditions and need care for relatively extended periods—more than 25 days, on average.*
  - Unlike LTCHs, other types of hospitals, such as acute-care hospitals (ACH), do not have length of stay requirements for Medicare payment.**
  - Most LTCH patients are transferred from an intensive or critical care unit of an ACH.

*The Social Security Act permits certain LTCHs to maintain an average length of stay of more than 20 days. See 42 U.S.C. §1395ww(d)(1)(B)(iv)(II).

**Medicare is the federal health insurance program for people aged 65 and older, certain individuals with disabilities, and individuals with end-stage renal disease. Among other things, Medicare covers inpatient hospital stays and physician services.

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Introduction (cont.)

- In fiscal year (FY) 2009, about 7 percent of hospitals were LTCHs, up from 4.5 percent in FY 2001.
  - Changes in the Medicare payment system, among other factors, contributed to the increase in the number of LTCHs.
  - After growth in the number of LTCHs, Congress placed a moratorium on the establishment of new LTCHs and on increases in bed size for existing LTCHs, with limited exceptions, beginning in 2007.*
- Medicare payments to LTCHs
  - Medicare paid about $5 billion in FY 2009 for care provided in 434 LTCHs for about 140,000 discharges—an average of more than $32,000 per discharge.**
  - Following a 2010 article in *The New York Times*, you expressed concern about the oversight of and quality of care provided in LTCHs.***

*The Medicare, Medicaid, and SCHIP Extension Act of 2007, Pub. L. No. 110-173, § 114(d), 121 Stat. 2492, 2503-04.

**According to CMS, there were 439 LTCHs as of November 2010.

***Alex Berenson, "Long-Term Care Hospitals Face Little Scrutiny," *The New York Times*, February 10, 2010.

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Objective

- Our briefing focuses on the oversight of LTCHs and how it differs from the oversight at other types of hospitals and nursing homes.

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Scope and Methodology

- To describe oversight of LTCHs, other types of hospitals—ACHs, psychiatric hospitals, and rehabilitation hospitals—and nursing homes*
  - We reviewed documents and interviewed officials from
    - The Centers for Medicare & Medicaid Services (CMS), which contracts with state survey agencies to survey hospitals, nursing homes, and other facility types that participate in the Medicare and Medicaid programs;** and
    - The Joint Commission (TJC), an accreditation organization (AO) that surveys most hospitals, including most LTCHs.
  - We analyzed data from CMS on FY 2009 survey activities, facility characteristics, and sanctions applied to these facilities from FY 2005 through FY 2009.
    - We obtained data on these FYs from CMS's Providing Data Quickly (PDQ) Website, which we downloaded on September 14, 2010.***
  - We analyzed data from TJC on FY 2009 survey activities and accreditation actions applied to these types of hospitals from FY 2007 through FY 2009.

*We compared LTCHs to psychiatric hospitals and rehabilitation hospitals because these hospitals often provide post acute care. We included ACHs because LTCH patients are transferred from an ACH. Some ACHs have psychiatric and rehabilitation units, which are excluded from the inpatient prospective payment system (IPPS), that provide services similar to psychiatric or rehabilitation hospitals; they have the same CMS identification number as the ACH in which they are located and are considered part of the ACH. Throughout these slides, we use "all types of hospitals" to refer to LTCHs, ACHs, and psychiatric and rehabilitation hospitals. We included information on hospitals and nursing homes from all 50 states, the District of Columbia, and 5 territories—American Samoa, Guam, Puerto Rico, the Commonwealth of the Northern Mariana Islands, and the United States Virgin Islands.

**Medicaid is the joint federal-state health care financing program for certain categories of low-income individuals.

***PDQ was created for use by CMS and state survey agencies and provides data on survey activities. PDQ is updated weekly.

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Scope and Methodology (cont.)

Data Limitations

- We excluded critical access hospitals, children's hospitals, and cancer hospitals because they generally do not provide post acute care services.
- We generally excluded two of the three AOs that accredit hospitals from our analysis—the American Osteopathic Association and Det Norske Veritas Healthcare, Inc.—because combined they surveyed 2 percent of LTCHs in 2009; however, we interviewed officials at these AOs to understand their accreditation policies.
- We generally used FY 2009 data for our analyses because FY 2009 was the most recent year for which complete data were available; these data included information on any facility that operated during FY 2009.

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Scope and Methodology (cont.)

- To ensure the reliability of the data we analyzed, we interviewed CMS and TJC officials, reviewed CMS and TJC documentation, and traced a selection of CMS records to verify internal consistency. Based on the information obtained from CMS and TJC, we determined that the data were sufficiently reliable for the purposes of this report.

- We conducted this performance audit from July 2010 through November 2010 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 objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

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Background

Types of Hospitals

- **ACHs**: Provide general, short-term care for a broad range of medical conditions and provide diagnostic or therapeutic services, surgery, and limited rehabilitation services.
  - Medicare pays for ACH services using the inpatient prospective payment system (IPPS). IPPS rates are based on the average costs per case for each diagnosis.
- While all hospitals are expected to treat individuals who require an acute level of care, some may also specialize in post acute care. Other types of hospitals (excluded from the IPPS)* that may specialize in post acute care include:
  - **LTCHs:** Provide acute and post acute care for relatively extended periods of time, such as for individuals requiring ventilator care.
  - **Psychiatric hospitals:** Provide clinical psychiatric services to patients with mental illness.
  - **Rehabilitation hospitals:** Provide intensive rehabilitation to patients recovering from medical conditions.

*These facilities are paid under prospective payment systems that are specific to each facility type.

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Background (cont.)

Hospital Categories

- Freestanding Hospitals
  - Are self-contained hospitals, not located in or on the campus of another hospital.
  - Are identified with a unique CMS identification number.*
- Hospitals within Hospitals (HwH)
  - Are located in a building used by another hospital—known as the host hospital—or in one or more separate buildings located on the same campus as another hospital.
  - Must be licensed and operate separately from the host hospital, maintain a separate board and administrative structure, and have separate medical staff to be excluded from IPPS.
  - Are identified with a unique CMS identification number.
  - According to CMS officials, approximately half of LTCHs are HwHs.
    - Other types of hospitals—including psychiatric and rehabilitation hospitals—can also be HwHs, but CMS officials told us that this is less common.

*Hospitals that separately participate in the Medicare program are assigned a unique identification number by CMS, called the CMS Certification Number.

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Background (cont.)

Nursing Homes

- Provide skilled nursing, rehabilitation, and/or custodial care to elderly and disabled individuals.
  - Medicare covers up to 100 days of skilled nursing home care following a hospital stay.
  - Medicaid covers nursing home stays for certain low-income individuals.
  - Combined Medicare and Medicaid payments for nursing home services in 2008 were about $82 billion—with a federal share of $58 billion—which represented about 45 percent of total U.S. nursing home expenditures.*
- Can be freestanding or located within hospitals.**
- Ninety percent provide services for both Medicare and Medicaid patients; of the remaining 10 percent, half accept Medicare patients only and half accept Medicaid patients only.

*FY 2008 data were the most recent data available at the time we did our work.

**Freestanding and hospital-based nursing homes are considered to be independent facilities and are identified with unique CMS identification numbers.

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Background (cont.)

Differences in Hospital and Nursing Home Ownership

- Fifty-eight percent of LTCHs are for-profit.
  - Thirty-one percent of LTCHs are owned by two for-profit chains.
    - Select Medical Corporation owns 18 percent of LTCHs.
    - Kindred Healthcare owns 13 percent of LTCHs.
- In contrast, 27 percent of all types of hospitals are for-profit.

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Background (cont.)

Differences in Hospital Ownership, FY 2009

	LTCHs	ACHs[a]	Psychiatric hospitals	Rehabilitation hospitals	Total
	Number (percentage) of hospitals				
For-profit	252 (58)	764 (21)	154 (30)	139 (61)	**1,309 (27)**
Nonprofit	150 (34)	2,185 (60)	136 (26)	80 (35)	**2,551 (53)**
Government	32 (7)	706 (19)	224 (44)	10 (4)	**972 (20)**
Total	**434 (100)[b]**	**3,655 (100)**	**514 (100)**	**229 (100)**	**4,832 (100)**

Source: GAO analysis of CMS data.

Note: Numbers do not always sum to 100 percent because of rounding.

[a]Some ACHs have IPPS-excluded psychiatric and rehabilitation units that provide services similar to those of psychiatric and rehabilitation hospitals, but these units have the same CMS identification number as the ACH in which they are located.

[b]According to CMS, there were 439 LTCHs as of November 2010.

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Background (cont.)

Differences in Nursing Home Ownership, FY 2009

- The majority (68 percent) of nursing homes are for-profit.

	Freestanding	Hospital-based	Total nursing homes, by type of ownership
	Number (percentage) of nursing homes		
For-profit	10,655 (72)	152 (13)	**10,807 (68)**
Nonprofit	3,453 (23)	730 (62)	**4,183 (26)**
Government	640 (4)	293 (25)	**933 (6)**
Total nursing homes	**14,748 (100)**	**1,175 (100)**	**15,923 (100)**

Source: GAO analysis of CMS data.

Note: Numbers do not always sum to 100 percent because of rounding.

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Background (cont.)

Geographic Distribution of LTCHs, ACHs, and Nursing Homes

- LTCHs are not evenly distributed across the nation (see next slide).
  - Four states—ME, NH, VT, WY—do not have LTCHs.
  - One state—TX—has 76 LTCHs (18 percent of LTCHs).
  - Patients who can be treated by LTCHs may instead receive care in ACHs, other types of hospitals, or nursing homes.
- In contrast, every state has ACHs and nursing homes, although distribution patterns vary (i.e., rural vs. urban).*

*Additionally, two U.S. territories do not have nursing homes—American Samoa and the Commonwealth of the Northern Mariana Islands.

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Background (cont.)

Geographic Distribution of LTCHs

Sources: GAO analysis of CMS data; Map Resources (map).

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Results

There are differences in the oversight of LTCHs, other types of hospitals, and nursing homes. These differences exist in four areas:

- Medicare and Medicaid participation requirements
- Quality standards
- Surveys
- Enforcement of quality standards

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Medicare and Medicaid Participation Requirements

Hospitals (All Types) and Nursing Homes

Hospitals—All Types

- Must demonstrate compliance, through unannounced on-site surveys, with Medicare quality standards established by CMS called Conditions of Participation (COP).
  - AOs conduct on-site surveys using standards that CMS has deemed to be at least equivalent to the COPs.

Nursing Homes

- Must demonstrate compliance, through unannounced on-site surveys, with Medicare and Medicaid nursing home quality standards that focus on the delivery of care, resident outcomes, and facility conditions.

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Medicare and Medicaid Participation Requirements (cont.)

Hospitals (All Types) and Nursing Homes

- Surveys for hospitals and nursing homes may be either
  - Routine—conducted at specific intervals or
  - Complaint—conducted in response to allegations of quality problems made by families, patients, health care workers, or others.
- Hospitals have a choice of being surveyed either by state survey agencies or AOs; nursing homes can only be surveyed by state survey agencies because no AOs are currently approved to survey them.*
  - For hospitals and nursing homes, surveys by state survey agencies result in their certification to participate in Medicare and/or Medicaid.
  - For hospitals, surveys by AOs result in facility accreditation, which CMS accepts as a basis for facility certification for Medicare participation.
- Facilities that fail to meet CMS or AO standards may be sanctioned, may lose accreditation, or both.

*AOs charge a fee for accreditation; state survey agency surveys are generally funded by Medicare.

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Medicare and Medicaid Participation Requirements (cont.)

State- and Accreditation-Organization-Surveyed Hospitals and Nursing Homes, FY 2009

	Hospitals					Nursing homes
	LTCHs	ACHs[a]	Psychiatric hospitals	Rehabilitation hospitals	Total hospitals	
	Number (percentage) of facilities					
State-surveyed	90 (21)	508 (14)	108 (21)	37 (16)	**743 (15)**	15,923 (100)
AO-surveyed[b]	344 (79)	3,147 (86)	406 (79)	192 (84)	**4,089 (85)**	N/A
Total	**434[c] (100)**	**3,655 (100)**	**514 (100)**	**229 (100)**	**4,832 (100)**	**15,923 (100)**

Source: GAO analysis of CMS data.

[a]Some ACHs have IPPS-excluded psychiatric and rehabilitation units that provide services similar to those of psychiatric and rehabilitation hospitals, but these units have the same CMS identification number as the ACH in which they are located.

[b]These numbers include hospitals that were accredited by TJC, Det Norske Veritas Healthcare, Inc., and the American Osteopathic Association. In FY 2009, hospitals accredited by TJC accounted for over 95 percent of accredited hospitals.

[c]According to CMS, there were 439 LTCHs as of November 2010.

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Quality Standards

Hospital COPs and Standards

- CMS has 74 standards organized under 23 COPs, including categories such as Medical Staff, Infection Control, and Emergency Services (see app. I).*
  - COPs were created in 1966 and significantly revised in 1986.
  - CMS has since updated the COPs several times on a variety of topics, including Patients' Rights.
  - In August 2010, CMS adopted an update to the Rehabilitation and Respiratory Services COPs.
  - Additionally, since 2000 CMS has been updating the guidance used to interpret and apply these standards.
- TJC's standards are organized into 17 categories, such as Medication Management and Leadership (see app. II).
  - TJC last updated its standards in 2010.

*Hospitals that provide certain specialized services may be required to meet additional COPs. For example, hospitals that provide transplant services must also meet the 13 COPs governing transplant services.

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Quality Standards (cont.)

Hospital COPs and Standards

In addition, TJC

- Measures hospitals against its National Patient Safety Goals, which are intended to promote specific improvements in patient safety.
- Requires hospitals to complete and submit annual self-assessments of compliance with standards.
- Requires hospitals to submit data for selected measures of clinical performance.

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Quality Standards (cont.)

Hospital COPs and Standards

- LTCHs are surveyed by state survey agencies and AOs using the same standards that are applied to ACHs; there are no additional survey standards or patient care requirements that are specific to LTCHs.
- Psychiatric hospitals and rehabilitation hospitals are surveyed using the same standards that are applied to ACHs, but must meet additional standards.*
  - Psychiatric hospitals must meet two additional COPs:
    - Adequate staffing of qualified mental health professionals, and
    - Medical record requirements that stress the psychiatric components of the evaluation(s) and treatment(s) provided.
  - Rehabilitation hospitals must:
    - Comply with IPPS exclusion requirements for inpatient rehabilitation facilities.

*Surveys for these additional standards are not conducted by AOs. Most surveys of the additional psychiatric hospital COPs are conducted by CMS contractors with psychiatric expertise. IPPS-excluded psychiatric and rehabilitation units within ACHs must meet additional standards similar to those for psychiatric and rehabilitation hospitals. These units meet the additional standards primarily through self-attestation. In addition, state survey agencies survey a small sample of the units annually to validate compliance.

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Quality Standards (cont.)

Hospital COPs and Standards

- According to CMS, the agency is developing LTCH-specific regulations in the hospital COPs in response to requirements in the Medicare, Medicaid, and SCHIP Extension Act of 2007.
  - CMS officials told us that the changes to the COPs may reflect the patient admission and discharge process, staffing requirements, and the level of patient care.
  - Estimated release for public comment is in May 2011, with the final rule expected to be issued in May 2012.
  - TJC officials also reported that they are developing standards specific to LTCHs.
- CMS will ensure that the LTCH-specific standards developed by TJC and other AOs are at least equivalent to those developed by CMS.

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Quality Standards (cont.)

Nursing Home Standards

- CMS has about 200 nursing home standards, such as preventing avoidable pressure sores, weight loss, and accidents. The standards are grouped into 15 categories, including quality of life, resident assessment, quality of care, and administration.
  - Uniform standards for Medicare and Medicaid were created in 1987.
  - Since 2000, CMS has been updating the guidance used to interpret and apply these standards.

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Surveys

Frequency of Routine Surveys—Hospitals (All Types)

- According to CMS policy, all state-surveyed hospitals are to be surveyed every 3 years, on average, with an interval not to exceed 5 years.*
  - From 25 to 33 percent of psychiatric hospitals are to be surveyed annually for their two additional COPs.
  - Rehabilitation hospitals must attest annually to meeting IPPS exclusion criteria.
- TJC-surveyed hospitals are to be surveyed every 3 years, but to ensure that surveys are unannounced, the interval between surveys ranges from 18 months to 39 months.**
  - According to CMS policy, AOs are required to conduct surveys every 3 years, on average.
- Survey schedules are established when a hospital enters the Medicare program.
  - Because HwHs are independently licensed and operated, their schedule is not necessarily tied to the host hospital's survey schedule.

*We have previously found that not all hospitals are surveyed within the maximum survey interval of 5 years. See GAO, *Medicare and Medicaid Participating Facilities: CMS Needs to Reexamine Its Approach for Funding State Oversight of Health Care Facilities*, GAO-09-64 (Washington, D.C.: Feb. 13, 2009).

**Effective January 1, 2011, TJC's survey interval will range from 18 months to 36 months.

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Surveys (cont.)

Frequency of Routine Surveys—Nursing Homes

- Nursing homes are to be surveyed every 12 months, on average, with an interval not to exceed 15 months.
- The nursing home survey interval is a statutory requirement.*

*See 42 U.S.C. § 1395i-3(g)(2)(A)(iii)(I), § 1396r(g)(2)(A)(iii)(I).

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Surveys (cont.)

Percentage of Hospitals and Nursing Homes That Had Routine Surveys, Based on Their Respective Survey Intervals

	Hospitals (FY 2007 through 2009)				Nursing homes (FY 2009)
	LTCHs	ACHs	Psychiatric hospitals	Rehabilitation hospitals	
State-surveyed[a]	63	87	79	54	99
TJC-surveyed	100[b]	100	100[b]	100[b]	N/A

Source: GAO analysis of CMS data and TJC data.

[a]State-surveyed hospitals are generally surveyed every 3 to 5 years; nursing homes are surveyed every year, on average.

[b]In these years, 100 percent of hospitals were surveyed, but a few hospitals received more than one survey during the 3-year period. To ensure that TJC surveys are unannounced, the survey interval ranges from 18 months to 39 months.

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Surveys (cont.)

Complaint Surveys—Hospitals (All Types)

- State survey agencies may conduct complaint surveys for allegations made against state-surveyed hospitals.
  - State survey agencies conduct an on-site survey to evaluate compliance with the COP(s) and standard(s) related to the complaint.
  - If surveyors find a hospital is out of compliance with one or more COPs during a complaint survey, the survey may be expanded to include all Medicare COPs.
- State survey agencies' complaint surveys for allegations involving AO-surveyed hospitals require CMS regional office authorization.
  - CMS may place the hospital under the state's jurisdiction until it returns to compliance with the COP(s).
- TJC may conduct complaint surveys when it receives complaints against hospitals it accredits.
  - TJC conducts an on-site survey to evaluate compliance with the standard(s) related to the complaint, but the survey may be expanded if warranted.
  - If a TJC complaint survey finds a hospital is out of compliance with one or more TJC standard(s) that are equivalent to CMS's COP(s), TJC conducts an on-site follow-up survey within 45 days.

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Surveys (cont.)

Complaint Surveys—Nursing Homes

- State survey agencies are to conduct all nursing home complaint surveys, which focus on specific allegations, and may be expanded to examine all Medicare and Medicaid standards.

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Surveys (cont.)

Number of Hospital and Nursing Home Complaint Surveys Conducted, FY 2009

	Hospitals				Nursing homes
	LTCHs	ACHs	Psychiatric hospitals	Rehabilitation hospitals	
State-survey-agency-conducted complaint surveys					
State-surveyed	70	483	67	10	47,160
TJC-surveyed[a]	234	4,195	304	70	N/A
TJC-conducted complaint surveys					
TJC-surveyed	14	177	38	5	N/A

Source: GAO analysis of CMS data and TJC data.

[a]State survey agencies may investigate complaints against hospitals that are surveyed by TJC.

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Enforcement of Quality Standards

State-Surveyed Hospitals—All Types

- State survey agencies may cite COP- and standard-level deficiencies on routine or complaint surveys.
  - COP-level deficiencies are more serious and can jeopardize or adversely affect the health of a patient if they recur or are not resolved.
  - Standard-level deficiencies are less serious and may not adversely affect the health of patients.
- Hospitals, including LTCHs, must prepare corrective action plans for both types of deficiencies.
  - For COP-level deficiencies, the state survey agency may return to the facility to ensure that the deficiencies have been corrected prior to the facility's next survey.
- State-surveyed hospitals that are unable to correct COP-level deficiencies may be terminated from the Medicare program.
- Survey findings are not available on CMS's Website for any type of hospital.

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Enforcement of Quality Standards (cont.)

Accreditation-Organization-Surveyed Hospitals—All Types

- TJC cites two types of requirements for improvement (RFI) for hospitals found out of compliance with its standards on routine or complaint surveys:
  - **Direct RFIs**: Cited when compliance issues are directly tied to quality, such as pain.
  - **Indirect RFIs**: Cited when compliance issues are indirectly related to quality, such as hospital leadership.
- Hospitals must document corrective actions to demonstrate that they have returned to compliance within 45 days for direct RFIs and within 60 days for indirect RFIs.
  - Hospitals may be resurveyed by TJC to verify the implementation of the corrective actions.
- TJC officials said they use the term RFI instead of deficiency because they consider the survey process to be an opportunity to consult with and educate hospitals about quality-of-care issues.

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Enforcement of Quality Standards (cont.)

Accreditation-Organization-Surveyed Hospitals—All Types

- A hospital that does not correct all of its RFIs within the required time frames may receive*
  - **Conditional accreditation:** The hospital is not in substantial compliance with applicable TJC standards; the hospital must remedy identified problem areas by submitting a plan of correction and be resurveyed, or
  - **Preliminary denial of accreditation:** The hospital has an immediate threat to health or safety for patients or has failed to resolve the requirements of a conditional accreditation, but the appeal process may result in a decision other than denial of accreditation.
- A hospital may be denied accreditation if it has exhausted all review and appeal opportunities, failed to pay the accreditation fee, or refused to allow a survey.
- CMS may subsequently terminate hospitals that lose their accreditation from the Medicare program.
- A hospital's final accreditation decision is posted on TJC's Website. According to TJC officials, findings of noncompliance with the standards evaluated during the survey are available on the Website only if the hospital received conditional or preliminary denial of accreditation.

*Effective January 1, 2011, TJC plans to change the titles of these categories.

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Enforcement of Quality Standards (cont.)

Nursing Homes

- Deficiencies identified by state survey agencies during routine or complaint surveys are classified according to
  - Scope: the number of affected residents, and
  - Severity: four levels, ranging from minimal harm to immediate jeopardy.
- Plans of correction are required for all deficiencies at the more than minimal harm level.
  - State survey agencies revisit facilities to ensure correction of serious deficiencies.

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Enforcement of Quality Standards (cont.)

Nursing Homes

- Generally, CMS imposes sanctions (enforcement actions) for serious deficiencies.
  - Nursing homes may be terminated from the Medicare and Medicaid programs but may also receive intermediate sanctions such as denial of payment or civil money penalties.
  - Past compliance with CMS standards is considered when determining severity of sanctions.
  - In FY 2009, CMS data showed that state survey agencies used intermediate sanctions in about 17 percent of all nursing homes.
- The deficiencies cited during nursing home surveys are available on CMS's Website.*

*See *Nursing Home Compare*, http://www.medicare.gov/NHcompare (accessed Sept. 29, 2010).

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Enforcement of Quality Standards (cont.)

Hospitals and Nursing Homes Terminated from Medicare, FY 2005 through FY 2009*

	Hospitals				Nursing homes
	LTCHs	ACHs	Psychiatric hospitals	Rehabilitation hospitals	
	Number (percentage) terminated				
State-surveyed	2 (2.5)	7 (1.3)	2 (2.1)	0 (0)	88 (0.6)
TJC-surveyed	0 (0)	3 (0.1)	4 (1.0)	1 (0.5)	N/A

Source: GAO analysis of CMS data.

*Hospitals and nursing homes may voluntarily choose to terminate their participation in the Medicare program for a number of reasons, including merger or change of ownership. We have excluded these facilities from our analysis.

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Summary of Differences in Oversight among LTCHs, Other Hospitals, and Nursing Homes

Although some aspects of the oversight of LTCHs are similar to those of other types of hospitals and nursing homes, there are more aspects in which the oversight differs.

- Similarities
  - All facility types must meet certain minimum quality requirements in order to participate in the Medicare and Medicaid programs.
  - Compliance for all facility types is determined during unannounced, on-site surveys.
- Differences
  - While LTCHs are assessed using the same standards that are applied to ACHs, other types of hospitals have additional standards or patient care requirements that are specific to their facility type; nursing homes also have a specific set of standards that reflect the characteristics of the population served.

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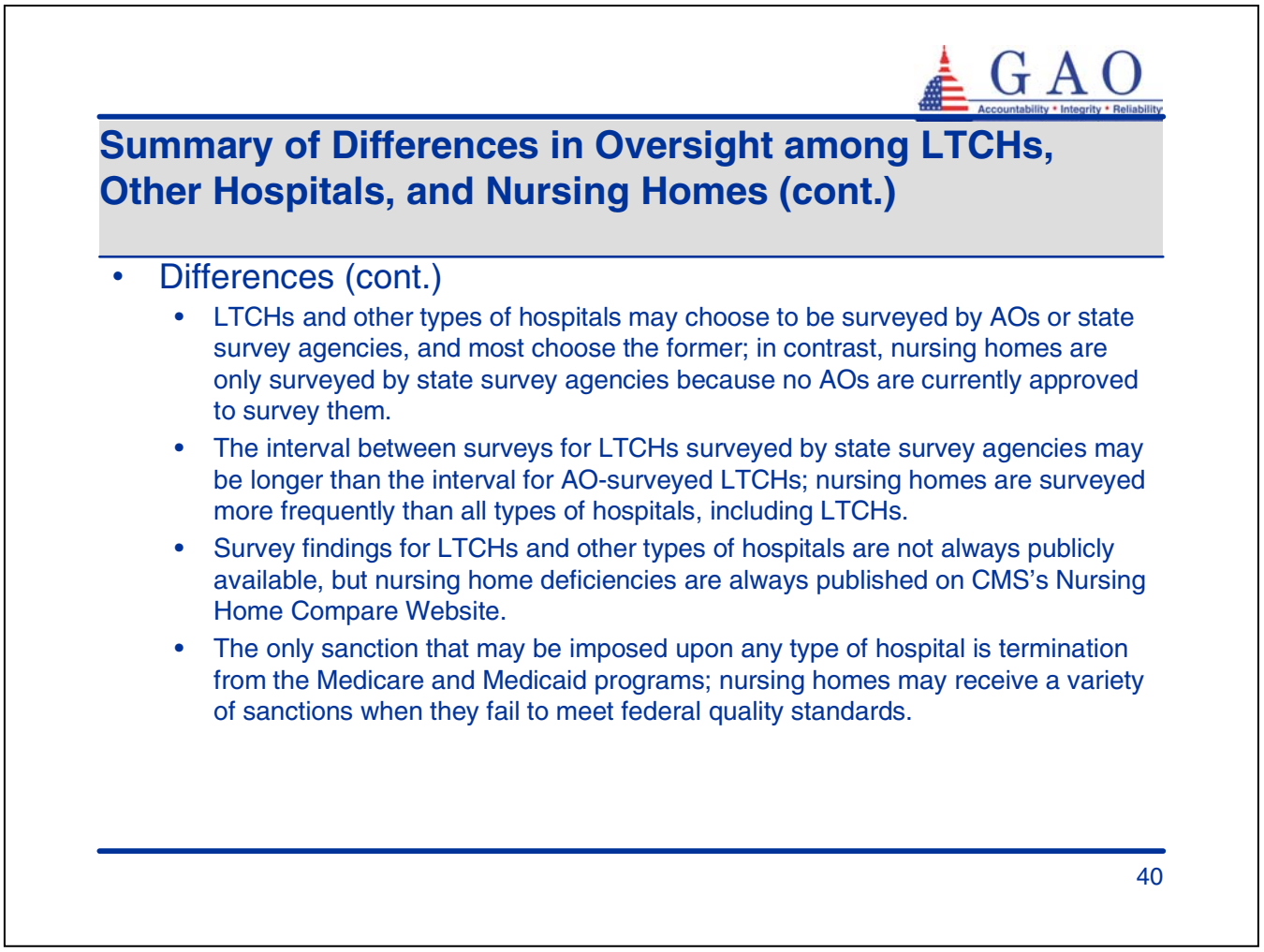
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Summary of Differences in Oversight among LTCHs, Other Hospitals, and Nursing Homes (cont.)
• Differences (cont.)
• LTCHs and other types of hospitals may choose to be surveyed by AOs or state survey agencies, and most choose the former; in contrast, nursing homes are only surveyed by state survey agencies because no AOs are currently approved to survey them.
• The interval between surveys for LTCHs surveyed by state survey agencies may be longer than the interval for AO-surveyed LTCHs; nursing homes are surveyed more frequently than all types of hospitals, including LTCHs.
• Survey findings for LTCHs and other types of hospitals are not always publicly available, but nursing home deficiencies are always published on CMS's Nursing Home Compare Website.
• The only sanction that may be imposed upon any type of hospital is termination from the Medicare and Medicaid programs; nursing homes may receive a variety of sanctions when they fail to meet federal quality standards.
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Agency Comments

We provided a draft of these briefing slides to the Department of Health and Human Services (HHS) and TJC for comment, and HHS provided CMS's response (see app. III). CMS noted that it is in the process of developing a LTCH-specific regulation within the hospital COPs in response to requirements in the Medicare, Medicaid, and SCHIP Extension Act of 2007. CMS also noted that the briefing slides were a welcome resource for highlighting the statutory and other differences in how the agency exercises oversight of these types of health care facilities. Both CMS and TJC provided technical comments, which we incorporated as appropriate.

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Appendix I
CMS's 23 Hospital COPs

COPs reviewed by state survey agencies	
1. Anesthesia Services	If anesthesia services are provided, they must be well organized and directed by a qualified doctor of medicine or osteopathy. The service is responsible for all anesthesia administered.
2. Compliance with Federal, State, and Local Laws	The hospital must comply with applicable federal laws on patient health and safety and state and local laws on hospital and personnel licensing.
3. Discharge Planning	A hospital must have a discharge planning process applicable to all patients. Policies and procedures must be in writing.
4. Emergency Services	If emergency services are provided, they must be organized under the direction of a qualified member of the medical staff and have adequate medical and nursing personnel qualified in emergency care to meet the needs anticipated by the facility.
5. Food and Dietetic Services	Dietary services must be organized, directed, and staffed by qualified personnel. Contracted services must meet certain requirements.
6. Governing Body	The hospital must have a legally responsible governing body or persons charged with the responsibilities of a governing body.
7. Infection Control	A hospital's sanitary environment must avoid sources and transmission of infections and communicable diseases. It must have an active program to prevent, control, and investigate infections and communicable diseases.
8. Laboratory Services	The hospital must maintain, or have available, adequate laboratory services.

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Appendix I (cont.)

CMS's 23 Hospital COPs

COPs reviewed by state survey agencies	
9. Medical Record Services	A hospital must have a medical record service that has administrative responsibility for medical records.
10. Medical Staff	A hospital must have an organized medical staff that abides by bylaws approved by the governing body and is responsible for the quality of patient medical care.
11. Nuclear Medicine Services	If nuclear medicine services are provided, they must meet the needs of the patients in accordance with acceptable standards of practice.
12. Nursing Services	An organized nursing service must provide 24-hour nursing services that are supervised or furnished by registered nurses.
13. Organ, Tissue, and Eye Procurement	The hospital must have and implement written protocols on procurement, have adequate organ transplant policies, and meet the 13 COPs governing transplant services if transplants are performed in the hospital.
14. Outpatient Services	If outpatient services are provided, they must meet patient needs consistent with acceptable standards of practice.
15. Patients' Rights	A hospital must protect and promote each patient's rights.
16. Pharmaceutical Services	The hospital must have pharmaceutical services that meet patient needs.

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Appendix I (cont.)

CMS's 23 Hospital COPs

COPs reviewed by state survey agencies	
17. Physical Environment	Hospital construction, arrangements, and maintenance must ensure patient safety and provide diagnostic and treatment facilities and special hospital services appropriate to community needs.
18. Quality Assessment and Performance Improvement Program	A hospital must have an effective, hospitalwide quality assurance program.
19. Radiologic Services	The hospital must maintain, or have available, diagnostic radiologic services. Therapeutic services provided must meet professionally approved standards for safety and personnel qualifications.
20. Rehabilitation Services	If rehabilitation, physical therapy, occupational therapy, audiology, or speech pathology services are provided, they must be organized and staffed to ensure the health and safety of patients.
21. Respiratory Care Services	If respiratory services are provided, they must meet patient needs in accordance with acceptable standards of practice.
22. Surgical Services	If surgical services are provided, they must be well organized and provided in accordance with acceptable standards of practice. Outpatient services must be consistent with inpatient care quality in accordance with the complexity of services offered.
23. Utilization Review	Utilization review plans must provide for review of the services that a hospital and its medical staff provide to Medicare and Medicaid patients.

Source: GAO summary of CMS's hospital COPs.

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Appendix II
TJC's 17 Categories of Hospital Standards

Standards reviewed by TJC	
1. Environment of Care	The hospital must manage risks to its environment, including safety and security, hazardous materials and waste, medical equipment, utility systems, and fire. This standard also requires hospitals establish a safe, functional environment. The hospital is required to monitor and make improvements to the environment based on its analysis of environment of care issues.
2. Emergency Management	The hospital is required to develop a written emergency operations plan that includes how it will communicate, manage security and safety, and manage patients during emergencies. The hospital also evaluates the effectiveness of its emergency management plan.
3. Human Resources	The hospital is required to establish and verify staff qualifications, orient staff, and provide staff with training to support hospital care, treatment, and services. The hospital is required to assess staff competence and performance on a regular basis.
4. Infection Prevention and Control	The hospital must establish a systematic infection prevention and control program. The systematic approach to infection prevention and control includes requirements to plan, implement, and evaluate the program.
5. Information Management	The hospital must establish a plan for managing information and maintaining the security of the health information. The requirements include planning for continuity of information management processes in the event of any interruptions.
6. Leadership	The hospital is required to have a leadership structure to support operations and develop a culture of safety and quality. The requirements include leadership's responsibilities regarding relationships, communications, and systems performance and operations.
7. Life Safety	The hospital is required to design and manage its physical environment to prevent fires and protect individuals in the event of fires.
8. Medication Management	The hospital is required to safely, clearly, and appropriately manage the medication it procures, dispenses, administers, and monitors and reduce the potential for medication errors. The hospital is required to evaluate its medication management processes and take action on improvement opportunities.

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Appendix II (cont.)

TJC's 17 Categories of Hospital Standards

Standards reviewed by TJC	
9. Medical Staff	The medical staff and governing body of the hospital must provide oversight of the quality of care, treatment, and services delivered by the hospital's practitioners. The hospital uses a process to determine the competency of practitioners by collecting, verifying, and evaluating data relevant to the practitioners' professional performance. The hospital evaluates practitioner performance on an ongoing basis.
10. National Patient Safety Goals	The hospital's patient safety goals include improving the accuracy of patient identification, effectiveness of caregiver communication, and safety of using medications.
11. Nursing	The hospital is required to employ a qualified nurse executive to establish guidelines and direct the hospital's nursing services, policies, and procedures and delivery of care, treatment, and services. The nurse executive functions at the senior leadership level.
12. Provision of Care, Treatment, and Services	The hospital is required to accept, provide, and coordinate safe, interdisciplinary care, treatment, and services for all patients if it is able to meet their needs.
13. Performance Improvement	The hospital is required to collect and analyze data to monitor and continually improve performance. The hospital uses data to implement performance improvement activities and monitors the effectiveness of these activities.
14. Record of Care, Treatment, and Services	The hospital is required to maintain and audit complete, timely, authentic, and accurate medical records for each patient.
15. Rights and Responsibilities of the Individual	The hospital must respect, protect, and promote patients' rights.
16. Transplant Safety	The hospital is required to develop and implement policies and procedures for organ and tissue donation and procurement.
17. Waived Testing	The hospital is required to have current, approved, and readily available policies and procedures for waived testing.

Source: GAO summary of TJC's hospital standards.

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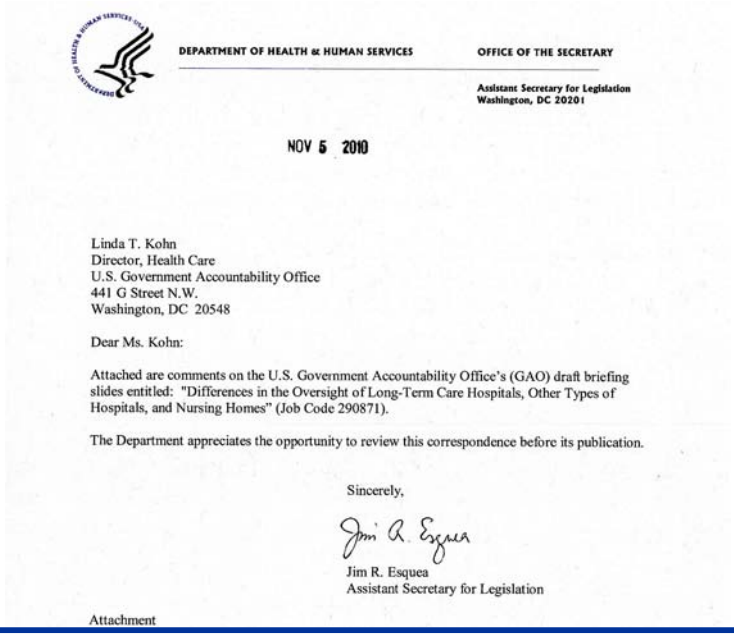
Appendix III
Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES — OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

NOV 5 2010

Linda T. Kohn
Director, Health Care
U.S. Government Accountability Office
441 G Street N.W.
Washington, DC 20548

Dear Ms. Kohn:

Attached are comments on the U.S. Government Accountability Office's (GAO) draft briefing slides entitled: "Differences in the Oversight of Long-Term Care Hospitals, Other Types of Hospitals, and Nursing Homes" (Job Code 290871).

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

Sincerely,

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

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Appendix III (cont.)

Comments from the Department of Health and Human Services

GENERAL COMMENTS OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT BRIEFING SLIDES ENTITLED: "DIFFERENCES IN THE OVERSIGHT OF LONG-TERM CARE HOSPITALS, OTHER TYPES OF HOSPITALS, AND NURSING HOMES (Job Code 290871)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the subject draft report. We have included a number of technical comments which we hope will facilitate an accurate overview of certain data on hospitals and nursing homes as well as of CMS' oversight mechanisms for the different types of facilities. We are committed to providing vigorous oversight of all types of hospitals and nursing homes in order to ensure that patients and residents receive safe, high quality care.

Long-term care hospitals (LTCHs) are a type of hospital that participates in the Medicare program and which provides acute care to clinically complex patients whose length of stay exceeds 25 days on average. Currently there are 439 LTCHs participating in the Medicare program. In order to be paid under the Medicare LTCH prospective payment system, hospitals must satisfy a number of specific requirements based on the Medicare payment regulations. In addition, like all other hospitals, LTCHs must comply with the hospital health and safety standards as a condition of participation in the Medicare program. The CMS is also in the process of developing LTCH-specific regulations within the hospital conditions of participation, consistent with the requirements for LTCHs found in the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Extension Act of 2007. Location of these provisions in the conditions of participation will allow enforcement through Federal surveys or surveys by Medicare-approved hospital accreditation programs. We believe that this will strengthen CMS' oversight of the quality of care in LTCH facilities.

The GAO's draft briefing slides *Differences in the Oversight of Long Term Care Hospitals, Other Types of Hospitals, and Nursing Homes,* job code 290871, provides a welcome resource for highlighting the statutory and other differences in the manner in which CMS exercises oversight of these various types of health care facilities. This report makes no recommendations.

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(290871)