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# LONG-TERM CARE HOSPITALS

## CMS Oversight Is Limited and Should Be Strengthened

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## Why GAO Did This Study

Allegations about quality-of-care problems have raised questions about the oversight of long-term care hospitals (LTCH), which provide care to individuals with multiple acute or chronic conditions. Medicare pays for about 80 percent of LTCH patient care. To ensure compliance with federal quality standards, accrediting organizations (AO) and state survey agencies under contract with the Centers for Medicare & Medicaid Services (CMS) conduct routine and complaint surveys. One AO, The Joint Commission (TJC), surveys most LTCHs. In a November 2010 report, GAO compared oversight of LTCHs to that of other facilities. In this report, GAO examined the extent to which CMS collects data about LTCHs' quality of care and oversees LTCH survey activities. To do this work, GAO analyzed CMS data on the results of LTCH surveys and discussed oversight activities with both CMS and AO officials. GAO assessed the reliability of the survey data and took steps to ensure that the data presented were reliable.

## What GAO Recommends

GAO recommends that CMS strengthen its oversight of LTCHs by improving available data on quality of care and by improving oversight of LTCH survey activities. HHS concurred with all of the recommendations. TJC agreed with most of them, but disagreed with the value of state oversight surveys of AO-surveyed LTCHs. We continue to believe that such surveys are an important part of CMS oversight of LTCH survey activities.

# LONG-TERM CARE HOSPITALS

## CMS Oversight Is Limited and Should Be Strengthened

### What GAO Found

CMS collects some data on the quality of care at LTCHs, but the data are limited for several reasons. First, CMS does not have detailed data on the results of surveys conducted by TJC prior to 2009 and has limited data on current surveys because TJC did not begin submitting detailed data to CMS until July 2009. CMS does have prior year and current survey data for state-surveyed LTCHs—about 16 percent of LTCHs. In addition, current survey results in CMS's databases may be incomplete because these databases do not always accurately identify (1) the organization responsible for surveying each LTCH and (2) whether a facility is, in fact, an LTCH. As of fiscal year 2010, CMS data showed a total of 447 LTCHs, but GAO identified 18 LTCHs incorrectly categorized in one CMS database as having been surveyed by state survey agencies. GAO also found 56 LTCHs either misidentified as acute care hospitals or missing from another CMS database that contains information on LTCHs surveyed by accrediting organizations. Second, CMS does not currently collect data on quality measures—information used to evaluate how health care is delivered—from LTCHs because, unlike other types of hospitals, LTCHs are not yet required to report them. The Patient Protection and Affordable Care Act enacted in 2010 requires LTCHs to report quality measures by 2014.

CMS's oversight of state survey agency and AO survey activities of LTCHs is limited. Two of CMS's three oversight approaches do not focus on LTCHs specifically, but on hospitals in general. First, CMS established performance measures—expectations regarding survey activities or the reporting of survey results—for survey organizations, but reports the results of its assessments for hospitals in general rather than for LTCHs specifically. Second, state survey agencies conduct surveys annually in AO-accredited hospitals—known as validation surveys—to assess the effectiveness of the AO surveys, but have not systematically included some LTCHs in the sample of hospitals subject to validation surveys. Additional validation surveys are done based on complaints. State survey agencies conducted more than 1,000 validation surveys over a 5-year period based on complaints in LTCHs that had been surveyed by TJC. CMS does not refer such complaints to TJC for investigation. As a result, TJC conducted few complaint surveys. Although CMS has instructed its regional offices to provide TJC with the results of these surveys, GAO found that these data were not always shared. CMS's third oversight approach—collection and analysis of data on the results of survey organizations' activities—has not utilized all the available data to identify problems that may require further investigation. GAO identified several potential areas where the data may assist CMS in more effectively overseeing survey activities at LTCHs, such as how effectively states triage and conduct complaint validation surveys.

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## Abbreviations

ACH	acute care hospital
AO	accreditation organization
ASSURE	Accrediting Organization System for Storing User Recorded Experiences
CMS	Centers for Medicare & Medicaid Services
COP	conditions of participation
HHS	Department of Health and Human Services
LTCH	long-term care hospital
MedPAC	Medicare Payment Advisory Commission
NQF	National Quality Forum
OSCAR	On-line Survey, Certification, and Reporting system
PPACA	Patient Protection and Affordable Care Act
RFI	requirements for improvement
TJC	The Joint Commission

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United States Government Accountability Office  
Washington, DC 20548

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September 15, 2011

The Honorable Max Baucus  
Chairman  
Committee on Finance  
United States Senate

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

Allegations about quality-of-care problems have raised questions about the oversight of long-term care hospitals (LTCH).<sup>1</sup> The more than 400 LTCHs are a small subset of the approximately 4,800 acute care, psychiatric, and rehabilitation hospitals that also provide post-acute care services to clinically complex individuals who have multiple acute or chronic conditions. Medicare is the predominant payer for LTCHs.<sup>2</sup> According to a recent report prepared for the Centers for Medicare & Medicaid Services (CMS), about 80 percent of patients admitted to LTCHs are covered by Medicare.<sup>3</sup> CMS is an agency within the Department of Health and Human Services (HHS).

As part of evaluating the quality of care provided to patients, CMS requires all hospitals, including LTCHs, to demonstrate compliance with federal Medicare quality standards. Compliance is assessed through (1) routine surveys, which are unannounced, on-site inspections conducted every 3 to 5 years, and (2) complaint surveys, which may be conducted when a complaint is received. LTCHs are surveyed using the same quality standards that are applied to acute care hospitals (ACH)—

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<sup>1</sup>See, for example, Alex Berenson, "Long-Term Care Hospitals Face Little Scrutiny," *The New York Times*, February 10, 2010.

<sup>2</sup>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.

<sup>3</sup>Communication from the Secretary of Health and Human Services transmitting a CMS report to the U.S. Congress, *Determining Medical Necessity and Appropriateness of Care for Medicare Long Term Care Hospitals*, March 2011.

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there are currently no additional quality standards that are specific to LTCHs.<sup>4</sup> Although LTCHs are a type of ACH, they do not necessarily provide the full range of surgical, diagnostic, and emergency services and may not have the same level of staffing provided in a typical ACH.<sup>5</sup> During a routine or complaint survey, surveyors may identify areas where a quality standard is not being met and may cite a deficiency, which demonstrates that the LTCH has failed to meet federal Medicare quality standards. In general, LTCHs may choose who conducts their routine surveys—a state survey agency under contract with CMS or a CMS-approved accreditation organization (AO). Most LTCHs—about 80 percent—are surveyed by one AO, The Joint Commission (TJC).<sup>6</sup> In turn, CMS is responsible for overseeing the survey activities of both state survey agencies and AOs, which depends on the availability of accurate and timely information. In our November 2010 report for you, we noted that CMS’s oversight focuses on hospitals in general and not LTCHs specifically.<sup>7</sup> In this report, we examine other issues you raised. Specifically, we examine the extent to which CMS (1) collects data about the quality of care at LTCHs and (2) oversees survey activities at LTCHs.

To examine the extent to which CMS collects data about the quality of care provided at LTCHs, we analyzed data on the results of routine and complaint surveys from CMS databases, including the number of and most commonly cited deficiencies. For state survey agencies, we analyzed deficiency data for surveys conducted from fiscal year 2005 through fiscal year 2010 to ensure that we had as many routine surveys for state-surveyed LTCHs as possible. For TJC-surveyed LTCHs, we analyzed deficiency data for surveys conducted in fiscal year 2010 because TJC did not begin submitting detailed data to CMS on the deficiencies identified during its surveys until July 2009. We compared the

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<sup>4</sup>According to CMS, the agency is developing LTCH-specific regulations in response to requirements in the Medicare, Medicaid, and SCHIP Extension Act of 2007. CMS officials told us that the changes to the standards may reflect the patient admission and discharge process, staffing requirements, and the level of patient care and that it plans to release a notice of proposed rule making in September 2011.

<sup>5</sup>In this report, references to ACHs exclude those that are classified as LTCHs.

<sup>6</sup>TJC is an independent, not-for-profit organization that accredits—through surveys—more than 19,000 health care organizations and programs in the United States.

<sup>7</sup>See GAO, *Long-Term Care Hospitals: Differences in Their Oversight Compared to Other Types of Hospitals and Nursing Homes*, [GAO-11-130R](#) (Washington, D.C.: Nov. 30, 2010).

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survey results for LTCHs to those for ACHs because LTCHs are a type of ACH. We also examined CMS efforts to develop quality measures. Quality measures are used to evaluate how health care is delivered, and information obtained from such measures can promote accountability among health care providers and help consumers make informed choices about their care.

To examine the extent to which CMS oversees survey activities at LTCHs, we examined (1) federal statutes, as well as CMS regulations and guidance, on state survey agency and AO survey activities; (2) performance measures that are used to assess the activities of state survey agencies and AOs; and (3) CMS's use of survey data to assess the adequacy of survey processes, including the results of surveys conducted by state survey agencies in TJC-surveyed LTCHs from fiscal year 2005 through fiscal year 2010. To better understand the type and quality of information that CMS and TJC share with each other, we examined two judgmentally selected state survey agency complaint surveys conducted at TJC-surveyed LTCHs. Criteria we used to select these surveys included media coverage, the involvement of different CMS regional offices, and complaint surveys that occurred both before and after CMS issued guidance in 2008 intended to improve information sharing between CMS and AOs. We interviewed officials at CMS headquarters and two regional offices to obtain information on the feedback provided to TJC on the results of these complaint surveys. Additionally, we analyzed CMS data on the results of all types of surveys, including the number of surveys, the number that cited serious deficiencies, and the resources used to conduct the surveys.

For both objectives, we reviewed documents and interviewed officials from CMS, including officials from CMS's Office of Survey and Certification, Division of National Systems, Office of Clinical Standards and Quality, and seven regional offices; TJC; National Quality Forum (NQF);<sup>8</sup> Medicare Payment Advisory Commission (MedPAC); and the two LTCH associations—Acute Long Term Hospital Association and National Association of Long Term Hospitals. We excluded two of the three AOs that survey LTCHs from our analyses—the American Osteopathic Association and Det Norske Veritas Healthcare, Inc.—because,

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<sup>8</sup>NQF is a nonprofit organization that fosters agreement on national standards for measurement and public reporting of health care performance data.

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combined, they surveyed approximately 3 percent of LTCHs in fiscal year 2010. To ensure the reliability of the data we collected, we interviewed officials from CMS and TJC to verify completeness and accuracy of our data and reviewed documentation related to the data collected to identify obvious errors. We identified data limitations involving accurate identification of the survey organization responsible for surveying each LTCH, which we discussed with CMS and the AOs. Based on these discussions and further analyses, we made appropriate adjustments to ensure the reliability of the data we report on LTCH quality of care. Based on these activities, we determined that the data were sufficiently reliable for our purposes.

We conducted this performance audit from November 2010 through September 2011 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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## Background

An LTCH is a type of ACH that specializes in treating critically ill individuals who require an intense level of health care with frequent physician and nurse visits for relatively extended periods—more than 25 days, on average.<sup>9</sup> For example, a significant subset of LTCH patients is dependent on a ventilator for breathing and receives therapy to help them breathe on their own.<sup>10</sup> Most LTCH patients have been transferred from intensive or critical care units of ACHs, which provide general, *short-term* care for a broad range of medical conditions.<sup>11</sup> LTCHs are not

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<sup>9</sup>LTCHs may initially be classified as an ACH until they demonstrate their average length of stay is at least 25 days. 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).

<sup>10</sup>In fiscal year 2009, the most frequently occurring diagnosis was respiratory diagnosis with ventilator support for 96 or more hours. Eight of the top 20 diagnoses, representing 31 percent of LTCH patients, were respiratory conditions. Patients treated by LTCHs vary in age. Twenty-three percent of Medicare LTCH patients are under the age of 65. See MedPAC, *Report to the Congress: Medicare Payment Policy* (Washington, D.C., March 2011).

<sup>11</sup>The average length of stay in an ACH is about 5 days. See MedPAC, *Report to the Congress: Medicare Payment Policy* (Washington, D.C.: March 2009).



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evenly distributed across the nation and patients who could be treated by LTCHs might instead receive care at ACHs, other types of hospitals, or nursing homes. Medicare generally pays more for hospital stays in LTCHs than in ACHs.<sup>12</sup> In fiscal year 2010, Medicare paid an estimated \$4.7 billion for care provided in more than 400 LTCHs for about 138,000 discharges, which averages more than \$34,000 per discharge.

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## Surveys, Survey Organizations, and Standards

To assess whether LTCHs meet federal quality standards, state survey agencies and AOs conduct two types of surveys—routine and complaint. Routine surveys are unannounced and are conducted at specific intervals. State survey frequencies are resource driven and depend on CMS’s annual funding level for such activities.<sup>13</sup> CMS’s policy has been for state survey agencies to conduct surveys every 3 to 5 years since fiscal year 2001. In contrast, AO policy is to conduct surveys every 3 years.<sup>14</sup> Complaint surveys are conducted in response to allegations of quality problems made by families, patients, health care workers, or others and provide survey organizations the opportunity to intervene promptly if problems arise between routine surveys. Complaint surveys may be conducted either by a state survey agency or an AO. However, most complaints are filed with state survey agencies, which conduct complaint surveys both at the LTCHs they survey as well as at AO-surveyed LTCHs. Complaint surveys focus on the specific allegations made and surveyors generally only assess the hospital’s compliance with standards related to those allegations.

In general, hospitals have a choice of who conducts their surveys—state survey agencies using federal Medicare standards or CMS-approved AOs that use requirements CMS has determined to be at least equivalent to those standards.<sup>15</sup> Federal Medicare standards consist of 74 standards

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<sup>12</sup>ACHs are paid under the inpatient prospective payment system whose rates are based on the average costs per case for each diagnosis. LTCHs are paid under a different prospective payment system that pays higher rates that reflect the resources required to treat medically complex patients.

<sup>13</sup>For more information on CMS funding to survey the various types of facilities that participate in Medicare, 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).

<sup>14</sup>TJC’s hospital accreditation survey interval ranges from 18 to 39 months.

<sup>15</sup>Appendixes I and II in [GAO-11-130R](#) summarize federal and TJC hospital standards.

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that are organized under 23 conditions of participation (COP), including categories such as Medical Staff, Infection Control, and Emergency Services. TJC, one of three AOs approved by CMS to survey hospitals, surveys the majority of LTCHs. TJC's standards for hospitals are organized into 17 categories, such as Medication Management, Leadership, and Medical Staff; each category consists of numerous standards. Prior to the Medicare Improvements for Patients and Providers Act of 2008, TJC had unique statutory deeming authority for hospitals and did not need to apply to CMS to be recognized as a national accreditation body for hospitals. This legislation revoked TJC's statutory deeming authority effective July 15, 2010, and gave CMS the authority to review and approve TJC's hospital accreditation program. As a result, in 2009, CMS evaluated the standards and processes used by TJC to conduct hospital surveys, including a comparison of TJC's standards to Medicare's and a review of the qualifications of its surveyors.<sup>16</sup> CMS approved TJC's hospital accreditation program effective July 15, 2010, through July 15, 2014.

When surveyors find quality problems during routine and complaint surveys, they cite either deficiencies or requirements for improvement (RFI), depending on the survey organization.

- State survey agencies cite deficiencies that are characterized as either standard- or COP-level based on the seriousness of the deficiency. Standard-level deficiencies denote less serious quality problems, while COP-level deficiencies are cited when the problems are serious or systemic in nature. A serious problem is defined as a shortcoming in a hospital's quality of services that adversely affects, or has the potential to adversely affect, the quality of patient care. When deficiencies are found, a hospital may be required to submit a plan of correction, detailing how and when it will address the deficiencies. If a hospital does not correct the deficiencies cited within the required time frame, CMS may terminate the hospital's participation in the Medicare program.

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<sup>16</sup>CMS required TJC to make changes to its survey standards to ensure consistency with federal quality standards for hospitals. For example, TJC required the hospitals it surveys, including LTCHs, to have an infection control officer, but did not spell out this official's responsibilities; CMS required TJC to do so.

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- TJC cites direct and indirect RFIs when hospitals are found to be out of compliance with TJC's standards on routine or complaint surveys. According to TJC, direct RFIs are cited when compliance issues are directly tied to quality, such as untreated pain; while indirect RFIs are cited when compliance issues are indirectly related to quality, such as hospital leadership. A hospital that does not correct all of its RFIs may receive conditional or preliminary 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 from Medicare participation if they lose their accreditation.

CMS collects information on state survey results in its On-line Survey, Certification, and Reporting system (OSCAR).<sup>17</sup> To collect data on the results of AO surveys, CMS established its Accrediting Organization System for Storing User Recorded Experiences (ASSURE) database in 2008. On a quarterly basis, all AOs update ASSURE with survey results that are crosswalked from their own standards and RFIs to federal Medicare quality standards and deficiencies.

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## Hospital Quality Measures

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 provided for the establishment of hospital quality measures and created a penalty for hospitals that do not report related data beginning in 2005.<sup>18</sup> Those hospitals that fail to report quality data are subject to a 2.0 percent reduction in the hospital's annual Medicare payment rate for the subsequent year.<sup>19</sup> This payment reduction applies to hospitals paid under Medicare's inpatient prospective payment system, which covers most types of hospitals but not LTCHs. ACHs began voluntarily reporting data for quality measures in 2004. For fiscal year 2011, there are 60 quality measures organized into six areas, including heart attack, heart failure, and pneumonia. For example, the pneumonia quality measures assess several aspects of care, including whether the patients received an antibiotic within 6 hours of arriving at the hospital and if the appropriate antibiotic was provided. In April 2005, CMS launched a Web site called

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<sup>17</sup>OSCAR is an older database that CMS is phasing out. The successor to OSCAR is the Quality Improvement Evaluation System.

<sup>18</sup>Pub. L. No. 108-173, §501(b), 117 Stat. 2066, 2289-90.

<sup>19</sup>42 U.S.C. § 1395ww(b)(3)(B)(viii).

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“Hospital Compare” to make information on hospital data available to consumers.<sup>20</sup> CMS posts information for each hospital’s quality measures on a quarterly basis.

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## CMS Survey Activity Oversight

CMS and its 10 regional offices oversee state and AO survey activities in order to monitor the performance of survey organizations and hold them accountable for meeting CMS’s survey requirements. To do so, CMS: (1) established performance measures, (2) has states conduct validation surveys of AO-surveyed hospitals, and (3) collects data from survey results for all types of hospitals.

State survey agencies and AOs have separate performance measures. State survey agency performance measures focus on states’ ability to meet the requirements for the survey and certification program.<sup>21</sup> These measures are organized into three sections: frequency, quality, and enforcement. For example, state performance measures assess states’ abilities to prioritize and conduct complaint surveys within specific time frames. AO performance measures focus on their ability to provide CMS with consistent, accurate, complete, and timely information on the facilities they survey. In October 2008, CMS established three categories of performance measures for AOs: (1) use of an electronic database to track accreditation and enforcement activity; (2) submission of facility notification letters—which contain information on individual facilities’ accreditation status—for all accreditation actions; and (3) submission of survey schedule information. CMS monitors each AO’s performance on the measures and provides written feedback on a quarterly basis. CMS reports to the Congress annually on the extent to which TJC and other AOs meet its performance measures.<sup>22</sup>

Validation surveys are conducted to measure the effectiveness of the AO survey process in identifying areas of serious non-compliance with federal Medicare quality standards in accredited facilities, such as LTCHs. Validation surveys have consequences for both AOs and facilities. State

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<sup>20</sup>See Hospital Compare, <http://www.hospitalcompare.hhs.gov>.

<sup>21</sup>CMS refers to the state survey agency performance measures as performance standards.

<sup>22</sup>The facility types included in the performance measures are hospitals, critical access hospitals, home health agencies, hospice providers, and ambulatory surgical centers.

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survey agencies conduct two types of validation surveys. The first type is a full survey of a sample of AO-surveyed facilities, known as traditional validation surveys. Traditional validation surveys are generally conducted within 60 days following a routine survey conducted by an AO. CMS selects a sample of hospitals for these surveys based on the hospital's most recent routine survey date and available resources. While CMS policy calls for approximately 1 percent of AO-surveyed hospitals to receive traditional validation surveys each fiscal year, since fiscal year 2007 CMS has supplemented the funding provided to states in order to increase the sample size to 2 percent or higher.<sup>23</sup> Because of budgetary constraints, the number has fluctuated from a 10-year high of 235 in fiscal year 1999 to about 90 in fiscal year 2009.<sup>24</sup> The second type of validation survey is a complaint validation survey, which occurs when a state survey agency investigates a complaint for a hospital surveyed by an AO. Unlike traditional validation surveys that are conducted within 60 days of a routine survey, complaint validation surveys are generally conducted when the complaint is received. Such surveys initially focus on the condition(s) alleged to be out of compliance. If the complaint validation survey cites one or more COP-level deficiencies, the facility is placed under the jurisdiction of the state survey agency. Subsequently, the state survey agency conducts a full survey of all COPs.<sup>25</sup> When all COP-level deficiencies have been corrected, the facility again becomes the responsibility of the AO.

CMS submits an annual report to Congress after the end of the fiscal year—known as the CMS Financial Report—that includes information on traditional validation surveys conducted at hospitals surveyed by AOs. Based on such surveys, CMS calculates a hospital disparity rate for each AO. The disparity rate measures the extent to which an AO has failed to cite one or more deficiencies during its routine survey that were later identified by a state survey agency during a traditional validation survey. If

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<sup>23</sup>CMS increased the total number of hospitals surveyed to 2 percent for fiscal years 2008 and 2009 and 2.5 percent for fiscal year 2010.

<sup>24</sup>The approximately 90 traditional hospital validation surveys represented an increase from a 10-year low of 44 in fiscal year 2004. In addition, CMS began conducting traditional validation surveys of other accredited facilities such as home health agencies and ambulatory surgical centers in fiscal year 2007.

<sup>25</sup>In comparison, if a traditional validation survey cites one or more COP-level deficiencies, the subsequent survey conducted by the state survey agency only reviews those COPs that were originally found to be out of compliance.

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the validation survey results for an AO indicate a disparity rate that reaches the threshold of 20 percent or greater, CMS is to notify the AO that its approval to survey and accredit hospitals may be in jeopardy and that the agency may initiate a review.

CMS collects data on the results of state survey agency surveys in its OSCAR database and AO surveys in its ASSURE database. The databases include information such as the number and type of surveys conducted and any deficiencies cited, including the specific standard or COP out of compliance. In addition, OSCAR contains data on the number of surveyors and amount of time devoted to the health portion of the survey.<sup>26</sup>

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### **CMS Has Data on the Quality of Care at LTCHs, but Currently the Data Are Limited**

Although CMS collects some data on the quality of care at LTCHs, the data are currently limited. First, CMS does not have data on prior survey results for the majority of LTCHs because TJC only recently began submitting detailed deficiency data on the results of its surveys to CMS.<sup>27</sup> In addition, current survey results in OSCAR and ASSURE may be incomplete because these databases do not always accurately identify (1) which survey organization is responsible for surveying each LTCH or (2) whether a facility is, in fact, an LTCH. Second, CMS does not currently collect data for quality measures because LTCHs are not yet required to report them.

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### **CMS Has No Detailed Prior Survey Data and Incomplete Current Survey Results on the Majority of LTCHs**

Because TJC only recently began submitting detailed survey data to CMS, ASSURE has no prior data and limited current data—surveys conducted since July 2009—for TJC-surveyed LTCHs, which constitute a majority (about 80 percent) of such hospitals. As of December 2010, TJC had surveyed and submitted data on about half of the LTCHs it surveys.<sup>28</sup> CMS has prior and current survey data in OSCAR for state-surveyed

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<sup>26</sup>Surveys examine quality of care (the health portion of the survey) as well as physical environment, which includes fire safety.

<sup>27</sup>While TJC did not report at the level of specificity that included survey findings prior to implementation of ASSURE in 2009, it did provide CMS the outcome of surveys, such as accreditation status, demographic information, and up-to-date survey schedules.

<sup>28</sup>Because TJC surveys its hospitals about once every 3 years, ASSURE has about 18 months of data.

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LTCHs, which represent about 16 percent of LTCHs.<sup>29</sup> Appendix I reports prior and fiscal year 2010 data on the proportion of LTCHs with COP-level deficiencies, lists the most commonly cited deficiencies, and compares these results to those of ACHs. Because fiscal year 2010 data does not include at least one survey for each LTCH, these results may not reflect the quality of care across all LTCHs.

We found that there were 447 LTCHs listed in OSCAR or ASSURE as of fiscal year 2010.<sup>30</sup> However, both the OSCAR and ASSURE databases inaccurately identified the responsible survey organization and the ASSURE database was incomplete. For example,

- OSCAR categorizes 89 LTCHs as state-surveyed, but we found that only 71 of these LTCHs are actually state-surveyed. The remaining 18 LTCHs are surveyed by AOs. CMS officials told us that OSCAR data are not always updated when LTCHs switch from being surveyed by an AO to being surveyed by a state survey agency and vice versa.
- We found that 56 LTCHs were either misidentified in ASSURE as ACHs or were missing from the database. LTCHs may initially be classified as ACHs until they demonstrate their average length of stay is at least 25 days and then need to be reclassified. According to a TJC official, about 30 LTCHs submitted ACH identification numbers on their TJC accreditation applications and were thus misidentified in ASSURE.<sup>31</sup> CMS subsequently issued new LTCH identification numbers to these facilities, but TJC officials told us that neither CMS nor the LTCHs had notified them. In a few cases, the LTCHs' initial survey occurred after TJC's last quarterly ASSURE update, the LTCH had submitted the identification number of a nearby facility with the same owner, or the LTCH had closed. Finally, in a couple cases, TJC could not explain why the LTCH was not listed in ASSURE.

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<sup>29</sup>The remaining 3 percent of LTCHs were surveyed by other AOs.

<sup>30</sup>In November 2010, we reported that there were 434 LTCHs in fiscal year 2009. See [GAO-11-130R](#). Based on our current analysis, we found that there are 447 LTCHs.

<sup>31</sup>Hospital identification numbers consist of six digits. The first two digits identify the state where the hospital is located. For LTCHs, the remaining four digits range from 2000 to 2299. CMS officials told us that, as of July 2011, AOs will be required to identify the hospital subtype, such as ACH or LTCH, in ASSURE. We do not believe that this requirement would have revealed the problem that approximately 40 TJC-surveyed LTCHs were misidentified in ASSURE because they had ACH identification numbers.

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CMS officials told us that they recognize these limitations, but have not yet established an approach for addressing these issues.

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### CMS Does Not Require LTCHs to Report Data on Quality Measures, but Will Do So Beginning in 2014

CMS currently does not have quality measures for LTCHs because LTCHs were not required to report on the quality measures developed for most ACHs in 2003 or later. While LTCHs are not currently reporting on quality measures, under the Patient Protection and Affordable Care Act (PPACA) enacted in 2010, they must begin doing so by 2014. PPACA directed HHS to publish measures for LTCHs and required the department to consider measures endorsed by a consensus-based entity, such as NQF.<sup>32</sup> To identify these measures, CMS reviewed LTCH measures currently used by the National Association of Long Term Hospitals and TJC. CMS also has received feedback from MedPAC, convened a technical expert panel, and held stakeholder information sessions. In May 2011, CMS published a proposed rule on three potential quality measures that LTCHs would be required to report on from October 1, 2012, through December 31, 2012, for their fiscal year 2014 payment determination: (1) catheter-associated urinary tract infection rate, (2) central-line associated blood stream infection rate, and (3) new or worsened pressure ulcers.<sup>33</sup> None of the three measures have been endorsed by NQF for use by LTCHs, but NQF has endorsed their use in other settings. CMS is working with NQF to have these measures endorsed for the LTCH setting.<sup>34</sup> The proposed rule includes some additional quality measures that CMS may require LTCHs to report in the future, some of which, such as patient fall rate, also have been endorsed by NQF for other types of health care facilities.

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<sup>32</sup>The Secretary of Health and Human Services may specify measures that are not endorsed in cases where existing endorsed measures are not considered feasible or practical.

<sup>33</sup>Medicare Program: Hospital Inpatient Prospective Payment System for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System, 76 Fed. Reg. 25,788 (proposed May 5, 2011).

<sup>34</sup>The measure assessing catheter-associated urinary tract infection rate has been endorsed for use in hospital intensive care units. The central-line associated blood stream infection rate has been endorsed for hospital intensive care units and high risk nursery patients. The new or worsened pressure ulcer measures have been endorsed for short-stay nursing home patients.



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## CMS Oversight of Survey Activities at LTCHs Is Limited

CMS and its regional offices' oversight of state survey agency and AO survey activities in LTCHs is limited because two of its oversight strategies—performance measures and selection of hospitals for traditional validation surveys—focus on hospitals in general rather than LTCHs specifically. CMS's third oversight strategy—collection and analysis of survey data—is also limited because the agency does not utilize all of the available data to identify weaknesses in the survey process that may require further investigation. As a result of these oversight limitations, CMS cannot ensure that state survey agencies and AOs are held accountable and that they meet CMS's survey requirements.

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## CMS's Performance Measures for Survey Activities Do Not Focus on LTCHs

None of the performance measures that CMS uses to assess the survey activities of state survey agencies and AOs focus specifically on LTCHs. Thus, CMS analyzes data on survey activities at LTCHs together with data for other types of hospitals and facilities and does not analyze or report the results separately for LTCHs.<sup>35</sup> One of CMS's performance measures for state survey agencies examines the timeliness of state surveys. CMS's policy is for all hospitals to be surveyed every 3 to 5 years. We used OSCAR data to analyze the timeliness of routine surveys conducted by state survey agencies in LTCHs. For LTCHs that had both a current and prior state survey (52 of 71), we found that more than 5 years had elapsed between surveys for about 38 percent of LTCHs.<sup>36</sup> About 19 percent of LTCHs were surveyed by states within 3 years and about 42 percent were surveyed from more than 3 up to 5 years after their prior surveys.<sup>37</sup>

Similarly, CMS does not analyze the results of its AO performance measures separately for LTCHs. CMS's performance measures for AOs generally focus on the AOs' ability to provide the agency with timely,

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<sup>35</sup>CMS regional offices share the results of the hospital and facility performance measures with the respective state survey agency and CMS headquarters, which in turn shares each state's scores with all of the other states.

<sup>36</sup>Survey information for about 17 of the LTCHs surveyed by states only contained a recent, current survey; no prior survey data were available. We removed these surveys from our analysis and report only on those LTCHs that had both a current and prior state survey.

<sup>37</sup>These percentages do not total 100 percent because of rounding.

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complete, and accurate survey findings, facility notification letters, and survey schedules for all of the types of facilities they survey (such as hospitals, home health agencies, ambulatory surgery centers, and hospices).<sup>38</sup> In addition, CMS recently added a measure that assesses whether AOs are conducting surveys of the accredited facilities within a 3-year period. CMS provides feedback on its analysis of performance measures to each AO, including TJC, on an ongoing basis. These results are also reported to Congress in CMS's annual financial report.<sup>39</sup> However, CMS does not provide feedback to AOs or publicly report on the performance measures for any particular type of AO-surveyed facility, including LTCHs.

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### LTCHs Are Not Systematically Included in the Hospital Validation Survey Sample, and Results from Complaint Validation Surveys Are Not Always Shared with TJC

CMS does not systematically include 1 percent of AO-surveyed LTCHs—fewer than five—in its sample of traditional hospital validation surveys conducted by state survey agencies. In contrast, state survey agencies conduct a large number of complaint investigations at TJC-surveyed LTCHs—known as complaint validation surveys. However, the results are not always shared with TJC, limiting the effectiveness of oversight.

### Traditional Validation Surveys

CMS's policy requires that approximately 1 percent of AO-surveyed hospitals receive a traditional validation survey each year.<sup>40</sup> While CMS has used this strategy to oversee AO survey activities at hospitals generally, it has not done so for LTCHs specifically.<sup>41</sup> Agency officials told us that the sample was unlikely to have included LTCHs prior to 2011

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<sup>38</sup>In 2008, CMS adopted a policy of electronic information exchange with the AOs, including TJC, in order to facilitate the timely receipt of information, such as survey schedules and facility notification letters, from the AOs. Previously, CMS had received information from AOs, including TJC, through the U.S. Postal Service. Additionally, AOs are required to immediately notify CMS of COP-level deficiencies that pose an immediate jeopardy to patient(s) at accredited hospitals by calling CMS as well as providing information about the immediate jeopardy to CMS and the appropriate regional offices using the electronic mailboxes. Regional offices generate 'alerts' for CMS when an immediate jeopardy deficiency is cited.

<sup>39</sup>*CMS Financial Report Fiscal Year 2010* <http://www.cms.hhs.gov/CFOReport/>.

<sup>40</sup>CMS has supplemented the funding provided to states since fiscal year 2007 in order to increase the sample size to at least 2 percent.

<sup>41</sup>CMS does not conduct traditional validation surveys at state-surveyed LTCHs.

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because they had not made LTCH status a basis for assignment of validation surveys. However, using OSCAR data, we found that about 1 percent or more of TJC-surveyed LTCHs received a traditional validation survey each year from fiscal years 2006 through 2010.<sup>42</sup> The results of LTCH validation surveys were included in CMS's annual calculations of TJC's hospital disparity rates for fiscal years 2006 through 2009.

Following the publicized allegations of poor care at LTCHs, CMS decided to have state survey agencies conduct validation surveys in fiscal year 2011 at 34 AO-surveyed LTCHs.<sup>43</sup> CMS selected the LTCHs using a stratified random sample methodology that considered the workload of the state survey agencies and the locations of the LTCHs.<sup>44</sup> CMS officials were not definitive in how they would use the results of these LTCH validation surveys. They suggested that they may compare the results of these surveys, including the extent to which COP-level deficiencies are cited, to their prior analysis of state LTCH survey data and to survey data for other types of hospitals. However, these surveys do not constitute a solution to CMS's lack of a systematic way of including LTCHs in its annual sample of traditional validation surveys at hospitals because these surveys are a one-time activity and will not be conducted within 60-days of a routine survey. As a result, CMS will not be able to calculate a disparity rate, which measures the effectiveness of the AOs' survey process.

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<sup>42</sup>When we discussed these LTCH validation surveys with CMS officials, they told us that they use a spreadsheet and not OSCAR to track traditional validation surveys and to calculate each AO's hospital disparity rate. However, we found that some of the surveys we identified through OSCAR were not on CMS's spreadsheet, and that CMS included a few surveys conducted outside the 60-day window. CMS officials told us that surveys conducted outside of the 60-day window are generally excluded from the agency's calculation of a disparity rate. CMS officials explained that the spreadsheet is used to track the assignment of validation surveys because OSCAR cannot be used to determine which validation surveys were assigned to which state survey agencies.

<sup>43</sup>CMS officials told us that of the 34 LTCHs, 33 LTCHs are TJC-surveyed and 1 is surveyed by the American Osteopathic Association.

<sup>44</sup>According to CMS officials, they selected LTCHs in this way to avoid overburdening certain state survey agencies. As noted earlier, LTCHs are not evenly distributed across states.

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## Complaint Validation Surveys

Through state survey agencies, CMS conducts a significant number of complaint validation surveys in TJC-surveyed LTCHs while TJC conducts few complaint surveys in the LTCHs it surveys. From fiscal years 2006 through 2010, state survey agencies conducted 1,224 complaint validation surveys at TJC-surveyed LTCHs compared with TJC's 67 complaint surveys at LTCHs it surveys. CMS officials told us that state survey agencies receive more complaints than the TJC because patients and their advocates may not always be aware that complaints can be filed with an AO.<sup>45</sup> They also told us that complaint allegations, including the patients name and the name of the complainant could not be referred to the appropriate AOs for investigation because of privacy concerns unless the AO specifically asked for each complaint.<sup>46</sup> However, when we discussed this issue with both CMS privacy and program officials, they concluded that CMS regional offices could refer hospital complaints to AOs for investigation or share complaint information with AOs prior to a state complaint validation survey. TJC officials told us that they are willing to conduct complaint surveys in response to referrals from CMS.

CMS told us that while it had not shared actual complaints with AOs it had increased its communication with TJC, including the results of complaint validation surveys. For example, CMS provided its regional offices with the e-mail address of each AO in order to provide AOs with copies of hospital correspondence and the results of surveys conducted by state agencies in accredited facilities. However, TJC officials told us that CMS regional offices do not consistently provide the results of the complaint validation surveys and sometimes the information provided is not timely. We spoke with officials from two CMS regional offices that authorized two state agency complaint validation surveys at TJC-surveyed LTCHs in fiscal year 2007 and fiscal year 2009, respectively. Officials from one regional office told us that not all of the information on the results of complaint validation surveys was forwarded to TJC; thus, a letter might be sent to TJC that outlined the COP-level deficiencies cited, but not the standard-level deficiencies. TJC told us that they did not even know that an additional complaint validation survey at this facility had been

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<sup>45</sup>According to TJC, it has a hospital participation requirement that hospitals notify the public they serve about how to contact hospital management and TJC to report concerns about patient safety and quality of care.

<sup>46</sup>Previously, when complaint information was forwarded to AOs, it was redacted and, according to TJC officials, not useful.

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conducted in 2009 until we informed them. Officials from the other regional office said that they did not forward any information from the complaint survey, including the official record of all the deficiencies cited.<sup>47</sup> TJC officials also said that information on the findings from state complaint validation surveys could lead them to conduct their own survey or could be used by TJC as it prepares for the facility's next survey. Additionally, officials from the CMS regional offices we contacted told us that state survey agencies do not review the results of an AO's most recent routine survey prior to conducting complaint validation surveys and therefore, may not be familiar with any deficiencies cited by TJC. Given that complaint validation surveys may provide insights into concerns that occur between routine surveys, information sharing between CMS regional offices and AOs is an important aspect of effective oversight.

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### CMS Is Not Using All Available ASSURE and OSCAR Survey Data to Oversee Survey Activities at LTCHs

CMS has not yet analyzed ASSURE survey data to oversee TJC's LTCH survey activities or used these data in combination with OSCAR data to identify issues that may warrant further examination and strengthen oversight and accountability. By recognizing and adjusting for limitations in these databases, we identified several areas where the data may assist CMS in more effectively overseeing survey activities at LTCHs. For example:

- CMS has data on the results of all surveys conducted by both state survey agencies and TJC that could provide information on the proportion of LTCHs and ACHs cited with COP-level deficiencies by state survey agencies and TJC. Although CMS conducted an internal analysis of the proportion of surveys at LTCHs and ACHs that cited COP-level deficiencies, it used only OSCAR data, which primarily consists of complaint surveys conducted by state survey agencies. We did our own analysis using both ASSURE and OSCAR data and found that the inclusion of ASSURE data influenced whether LTCHs

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<sup>47</sup>These officials and those at other CMS regional offices we contacted told us that currently they do provide TJC and other AOs information about surveys. However, one regional office we spoke with forwards information from complaint validation surveys to TJC and other AOs only when COP-level deficiencies are cited.

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or ACHs had more COP-level deficiencies.<sup>48</sup> See app. I for the results of our data analysis.

- CMS has data on complaint validation surveys conducted in LTCHs that could provide information on how effectively states triage and conduct complaint surveys at TJC-surveyed LTCHs. For example, our analysis found that a small proportion of state complaint validation surveys cited deficiencies. Specifically, we found that about 6 percent of the 1,224 complaint validation surveys conducted at TJC-surveyed LTCHs between 2006 and 2010 had one or more COP-level deficiencies and about 66 percent did not cite any deficiencies.<sup>49</sup> We also found that two state agencies conducted nearly half (40 percent) of the complaint validation surveys, but cited almost no COP-level deficiencies.<sup>50</sup> CMS and TJC officials told us that the small proportion of state complaint validation surveys that cite COP-level deficiencies indicated that state survey agencies may not be adequately triaging complaints, that is, some of these complaints may not have warranted on-site surveys. In addition, CMS officials suggested that states may have cited deficiencies at the standard level to avoid conducting a full survey and may not have reviewed all standards related to the COP alleged by the complainant to have been out of compliance.<sup>51</sup>
- CMS has data to compare the results from routine and complaint surveys that could provide information on the thoroughness of routine surveys at LTCHs that also had complaint validation surveys. CMS has not compared routine survey data for TJC-surveyed LTCHs it has in ASSURE with complaint validation survey data it has in OSCAR. We compared these two databases to determine if routine surveys by TJC had missed COP-level deficiencies identified by state complaint

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<sup>48</sup>Although our analysis included LTCH and ACH survey results that were crosswalked and submitted to ASSURE by TJC, CMS questioned the comparability between state survey findings and TJC's crosswalked survey results because of the different methods used.

<sup>49</sup>The remaining surveys cited standard level deficiencies.

<sup>50</sup>For example, one state conducted 51 complaint validation surveys at the same hospital over the 5-year period, but cited no COP-level deficiencies.

<sup>51</sup>CMS's State Operations Manual requires state survey agencies to conduct full surveys of an accredited facility when a COP-level deficiency is cited. The appropriate regional office is to review and approve a state survey agency's findings prior to the initiation of the full survey.

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validation surveys. We identified 32 complaint validation surveys that were conducted within 2 to 60 days of a TJC routine survey reported in ASSURE. Four of the 32 surveys identified COP-level deficiencies that were not identified on the LTCHs most recent survey by TJC. While there may be reasonable explanations, further information could improve CMS oversight of survey activities.

- CMS has data on the survey resources used during routine surveys by state survey agencies and TJC that could provide information on the efficiency and effectiveness of survey activities. We compared the survey resources—number of surveyors and amount of time devoted to conducting a survey—used by state surveyors and TJC for the health portion of routine surveys at similar sized LTCHs between 2006 and 2010. We found that state surveyors spent about two times as many hours per survey and utilized about two times more surveyors per survey than TJC. The appropriate level of resources for an LTCH survey is unclear and CMS, state survey agencies, and TJC may not be in agreement.

CMS officials told us that they are not using all available ASSURE and OSCAR survey data because they are currently focusing on obtaining complete and accurate information from TJC and other AOs. They told us that they intend to more fully use the available data in the future to oversee LTCH survey activities; however, they have not developed a plan to do so. One CMS official also told us that in the future the agency might consider merging the information collected in ASSURE with OSCAR, thereby establishing one database for hospital survey data.

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## Conclusions

LTCHs are a specialized type of ACH that care for very sick and clinically complex patients. Most patients in LTCHs have been transferred from an intensive care unit of another hospital because they need a continued intense level of care for an extended period of time. Because these patients are so vulnerable, it is important that oversight of the quality of care delivered by LTCHs is monitored and, if shortcomings are identified, action is promptly taken. However, our review found several limitations in the oversight of LTCHs that are cause for concern, including weaknesses that affect the availability of data to oversee the quality of care and the ability of CMS to hold both state survey agencies and accrediting organizations accountable for their survey activities.

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We found several weaknesses in the availability of data on the quality of care in LTCHs. The results of surveys are stored in more than one database, which affects CMS's ability to use the data to understand the quality of care in LTCHs. For example, CMS is unable to accurately identify all LTCHs from these databases and which entity—state survey agencies or AOs—is responsible for conducting routine surveys of the facility. The inability to accurately identify all LTCHs has implications, particularly when CMS implements a new COP for LTCHs and when LTCHs have to begin reporting quality measures. The fragmentation of data across different databases also affects CMS's ability to review the data for LTCHs specifically and ensure that the data are updated as needed and may inhibit the sharing of data between the state survey agencies and AOs, both of which may have surveyors in the same LTCHs at different times, conducting different types of surveys.

We also found weaknesses in CMS's ability to hold state survey agencies and accrediting organizations accountable. CMS's traditional strategies for holding these entities accountable—performance measures and validation surveys—do not focus on LTCHs. Although CMS conducts traditional validation surveys in hospitals in general as a means for assessing the effectiveness of an AO's survey activities, CMS cannot assure that LTCHs are systematically included in their review; when such surveys have been conducted in LTCHs, CMS has not separated out the LTCH surveys from surveys of all other hospitals and so is unable to identify whether there may be areas of concern specific to AO survey activities in LTCHs. Furthermore, CMS is not effectively using the data it collects from surveys to review and understand the activities conducted by state survey agencies and AOs. For example, there are differences in the workload and resources devoted to survey activities between state survey agencies and AOs; however, the reasons for these differences were not clear. CMS officials said they plan to more fully use the data in the future to oversee survey activities in LTCHs, but have not yet developed a plan for doing so.

CMS oversight of LTCHs is hampered by inaccurate data and ineffective use of the data it currently collects. By increasing the use of its existing databases and more effectively using the data it currently collects, CMS has the opportunity to improve the accuracy of the data it has and the effectiveness of its oversight. Unless CMS more effectively uses the data it collects, the agency cannot provide assurances that the quality of care in LTCHs meets federal quality standards and ensure that vulnerable patients are not at risk.



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## Recommendations for Executive Action

In order to improve the data available on the quality of care at LTCHs, the Administrator of CMS should take the following two actions:

1. Improve the accuracy of the databases that track LTCH survey results by:
  - working with AOs and state survey agencies to develop a complete and accurate list of the LTCHs that they each survey and an approach to ensuring that the list is updated in a timely manner, and
  - expanding the OSCAR database to include the results of all LTCH surveys, such as those conducted by TJC, which are currently stored in the separate ASSURE database.
2. Improve information sharing with TJC regarding complaint validation survey results for TJC-surveyed LTCHs, such as ensuring that all survey findings are shared in a timely fashion.

In order to improve CMS's oversight of survey activities at LTCHs, the Administrator of CMS should take the following three actions:

1. Conduct traditional validation surveys at a sample of LTCHs each fiscal year and include an LTCH disparity rate in its annual financial report to Congress.
2. Explore differences in survey workload and in the resources survey organizations devote to LTCH surveys in order to
  - identify areas for efficiencies, and
  - determine whether the workload associated with complaint validation surveys could be more equitably shared with TJC.
3. Develop a plan to use available data on survey activities to hold survey organizations accountable for conducting surveys consistent with CMS requirements for evaluating the quality of care provided by LTCHs.

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## Agency and Other External Comments and Our Evaluation

We provided a draft of this report to HHS and TJC for comment. In its written comments, HHS concurred with our recommendations and acknowledged that their implementation would further strengthen the continued improvement in the oversight of AOs that CMS has undertaken since fiscal year 2006. TJC agreed with most of our recommendations, but disagreed with the recommendation related to traditional validation surveys, that is, state oversight surveys at AO-surveyed LTCHs. HHS's and TJC's comments are reproduced in appendix II and III, respectively.

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## HHS Comments

HHS concurred with all five of our recommendations. With respect to our recommendation to improve the accuracy of the databases that track LTCH survey results, HHS noted that it had been working since 2007 to identify and correct serious problems in both the AO and CMS databases and had made significant progress. HHS acknowledged that one issue is that LTCHs must enroll initially as acute care hospitals and are later converted to LTCHs, which affects the identification of LTCHs in the database. HHS outlined steps it had taken to address the fact that we found many LTCHs identified as acute care hospitals in the ASSURE database. HHS also said that it has begun the process of converting ASSURE to a Web-enabled application, which would provide more flexibility and allow it to explore methods to increase the accuracy of the database.

HHS also concurred with our four other recommendations. HHS said that it intends to:

- reinforce existing CMS policy on sharing information with AOs and work with regional offices to enhance compliance,
- explore an option to increase its traditional validation survey sample for hospitals, which would permit the inclusion of a stratified sample of LTCHs annually,
- explore the differences in survey workload and resource allocation, which it characterized as definitely meriting attention, while working with regional offices to clarify the policy for triaging complaint surveys at AO-surveyed LTCHs and for referring certain complaints to the appropriate AO, and
- review the available data to determine to what extent it can be used to develop additional AO performance measures for evaluating quality of care at hospitals, including LTCHs.

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## TJC Comments

TJC agreed that there was room for improvement in CMS's oversight of the quality of care provided by LTCHs and of survey activities at such hospitals and noted that CMS had already taken positive steps toward achieving these goals. However, it questioned our conclusion that CMS oversight of LTCHs was limited. It suggested, instead, that a more accurate conclusion was that CMS oversight was not separated in a focused manner from that of other hospitals. We believe that our report appropriately acknowledged CMS's progress in collecting data from TJC since TJC's statutory deeming authority was revoked. We found that CMS oversight of LTCHs was limited because it was (1) focused on hospitals in general and not LTCHs specifically and (2) not effectively using the survey data it collected to review and understand the activities of state survey agencies and AOs at LTCHs.

TJC agreed with our recommendations to improve the accuracy of the survey databases, improve information sharing, and use available data to improve oversight. However, it disagreed with our recommendation to conduct traditional validation surveys at a sample of LTCHs each fiscal year and to include a LTCH-specific disparity rate in its annual financial report to Congress. Specifically, TJC questioned the value of LTCH-specific validation surveys for several reasons:

- TJC questioned whether validation surveys were the most appropriate measure of AO performance because we had previously reported that state surveyors understate (i.e., miss) serious deficiencies on nursing home surveys. We do not believe that these findings are directly applicable to traditional LTCH validation surveys because the findings cited by TJC relate to routine nursing home surveys. Moreover, understatement, if it did exist on validation surveys, would not diminish the fact that state surveyors have identified serious deficiencies that AOs should have, but did not cite. We agree with TJC that CMS should monitor complaint validation survey findings as another indicator of AOs performance. For example, we pointed out that state survey agencies identified condition-level deficiencies not cited by TJC on several complaint validation surveys that were conducted within 60 days of TJC's routine survey.
- TJC stated that the inclusion of a representative number of LTCHs as part of the annual validation survey schedule would require a significant increase in the federal budget allocated to validation surveys. TJC said this would be necessary in order to arrive at a statistically valid sample size that would in turn support a LTCH-specific disparity rate calculation. As we pointed out and HHS

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comments noted, CMS has been conducting a small number of traditional validation surveys at LTCHs each year—approximately 1 percent of LTCHs. In addition, HHS noted that it would explore an option to increase its traditional validation survey sample for hospitals, thereby permitting the inclusion of a stratified sample of LTCHs each year.


TJC noted that it had provided CMS with information such as the accreditation status resulting from surveys, demographic information, and up-to-date survey schedules prior to the establishment of ASSURE in 2009 and, therefore, it was inaccurate to say that CMS has no prior survey data on TJC-surveyed LTCHs. TJC's comments acknowledged that the information provided to CMS prior to 2009 did not include detailed information on the specific deficiencies identified. We added a footnote to our report acknowledging the information that TJC did provide to CMS before 2009 and clarified the report to make it clear that the prior survey data we are referring to involved detailed data on the deficiencies cited.

HHS and TJC also provided technical comments, which we incorporated as appropriate.

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As agreed with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Secretary of Health and Human Services, the Administrator of the Centers for Medicare & Medicaid Services, and other interested parties. In addition, the report will be available at no charge on the GAO Web site at <http://www.gao.gov>.

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



Linda T. Kohn  
Director, Health Care

# Appendix I: Condition-Level Deficiencies Cited at Long-Term and Acute Care Hospitals During Routine and Complaint Surveys

This appendix presents the Centers for Medicare & Medicaid Services (CMS) data on the results of surveys at long-term care hospitals (LTCH). In the course of our analyses, we identified some data limitations, which we discussed with both CMS and The Joint Commission (TJC). We report only data that we determined to be reliable.

CMS has several years worth of data on condition of participation-level (COP) deficiencies cited by state survey agencies at LTCHs, but TJC only began submitting similar data in July 2009. Table 1 shows data on COP-level deficiencies cited by state survey agencies from fiscal years 2005 through 2009. Table 2 shows fiscal year 2010 survey results for both state survey agencies and TJC for LTCHs and acute care hospitals (ACH). Fiscal year 2010 is the first full year for which data are available for both survey organizations. However, most hospitals did not have a routine survey in fiscal year 2010 because surveys are conducted every 3 to 5 years. Because fiscal year 2010 data does not include at least one survey for each LTCH, these results may not reflect the quality of care across all LTCHs. Finally, tables 3 and 4 show the most commonly cited COP-level deficiencies at LTCHs and ACHs surveyed by state survey agencies, during fiscal year 2010.

**Table 1: COP-Level Deficiencies Cited During Routine and Complaint Surveys Conducted by State Survey Agencies at LTCHs, Fiscal Years 2005 through 2009**

Survey organization	Routine surveys	Complaint surveys <sup>a</sup>	Total <sup>b</sup>
	Percentage of LTCHs with one or more COP-level deficiencies (Number of LTCHs that were surveyed)	Percentage of LTCHs with one or more COP-level deficiencies (Number of LTCHs that were surveyed)	
State survey agencies	21.8 (55)	24.8 (282)	<b>25.4 (307)</b>

Source: GAO analysis of OSCAR data.

<sup>a</sup>Both complaint and complaint validation surveys are included in these data. Complaint surveys are conducted by survey organizations at the LTCHs that they routinely survey. Complaint validation surveys are conducted by state survey agencies at LTCHs that are surveyed by accrediting organizations.

<sup>b</sup>Numbers may not add to totals because some LTCHs may have received both a routine and complaint survey during fiscal years 2005 through 2009.

**Appendix I: Condition-Level Deficiencies Cited at Long-Term and Acute Care Hospitals During Routine and Complaint Surveys**

**Table 2: COP-Level Deficiencies Cited during Routine and Complaint Surveys Conducted by State Survey Agencies and TJC at LTCHs and ACHs, Fiscal Year 2010**

Survey organization	LTCHs	ACHs
	Percentage of LTCHs with one or more COP-level deficiencies (Number of LTCHs that were surveyed)	Percentage of ACHs with one or more COP-level deficiencies (Number of ACHs that were surveyed)
<b>Routine surveys</b>		
State survey agencies	18.5 (27)	11.6 (268)
The Joint Commission	9.8 (123)	37.4 (911)
<b>Total</b>	<b>11.3 (150)</b>	<b>31.6 (1,179)</b>
<b>Complaint surveys<sup>a</sup></b>		
State survey agencies	14.7 (143)	7.4 (1,256)
The Joint Commission	12.5 (8)	14.5 (138)
<b>Total<sup>b</sup></b>	<b>14.6 (151)</b>	<b>8.1 (1,394)</b>

Source: GAO analysis of OSCAR and ASSURE data.

Note: Our analysis included crosswalked LTCH and ACH survey results submitted to ASSURE by TJC. CMS questioned the comparability between state survey findings and TJC's crosswalked survey results because of the different methods used.

<sup>a</sup>Both complaint and complaint validation surveys are included in these data. Complaint surveys are conducted by survey organizations at the LTCHs that they routinely survey. Complaint validation surveys are conducted by state survey agencies at LTCHs that are surveyed by accrediting organizations.

<sup>b</sup>Numbers may not add to totals because some LTCHs may have had one or more complaint surveys conducted by a state survey agency, as well as one or more complaint surveys conducted by TJC during the same year.

**Appendix I: Condition-Level Deficiencies Cited at Long-Term and Acute Care Hospitals During Routine and Complaint Surveys**

**Table 3: COP-Level Deficiencies Most Commonly Cited by State Survey Agencies during Routine and Complaint Surveys at LTCHs, Fiscal Year 2010**

<b>COP-level deficiency</b>	<b>Number of times cited</b>	<b>Percentage of all COP-level citations</b>
Nursing services	15	31.9
Patient rights	9	19.2
Infection control	5	10.6
Pharmaceutical services	4	8.5
Governing body	3	6.4
Medical record services	3	6.4
Food and dietetic services	3	6.4
Physical environment	2	4.3
Medical staff	1	2.1
Discharge planning	1	2.1
Surgical services	1	2.1
<b>Total</b>	<b>47</b>	<b>100<sup>a</sup></b>

Source: GAO analysis of OSCAR data.

Note: Both complaint and complaint validation surveys are included in these data. Complaint surveys are conducted by survey organizations at the LTCHs that they routinely survey. Complaint validation surveys are conducted by state survey agencies at LTCHs that are surveyed by accrediting organizations.

<sup>a</sup>Numbers may not add to 100 due to rounding.

**Appendix I: Condition-Level Deficiencies Cited at Long-Term and Acute Care Hospitals During Routine and Complaint Surveys**

**Table 4: COP-Level Deficiencies Most Commonly Cited during Routine and Complaint Surveys by State Survey Agencies at ACHs, Fiscal Year 2010**

<b>COP-level deficiency</b>	<b>Number of times cited</b>	<b>Percentage of all COP-level citations</b>
Patient rights	57	24.0
Governing body	38	16.0
Nursing services	37	15.6
Physical environment	26	10.9
Medical staff	18	7.6
Infection control	13	5.5
Pharmaceutical services	9	3.8
Surgical services	8	3.4
Discharge planning	7	2.9
Medical record services	5	2.1
Radiologic services	4	1.7
Respiratory care services	4	1.7
Food and dietetic services	3	1.3
Anesthesia services	3	1.3
Compliance with federal laws	2	0.8
Emergency services	2	0.8
Utilization review	1	0.4
Special conditions for hospitals	1	0.4
<b>Total</b>	<b>238</b>	<b>100<sup>a</sup></b>

Source: GAO analysis of OSCAR data.

Note: Both complaint and complaint validation surveys are included in these data. Complaint surveys are conducted by survey organizations at the LTCHs that they routinely survey. Complaint validation surveys are conducted by state survey agencies at LTCHs that are surveyed by accrediting organizations.

<sup>a</sup>Numbers may not add to 100 due to rounding.



# Appendix II: 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

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

AUG 24 2011

Dear Ms. Kohn:

Attached are comments on the U.S. Government Accountability Office's (GAO) draft report entitled: "LONG-TERM CARE HOSPITALS: CMS Oversight Is Limited and Should Be Strengthened" (GAO-11-810).

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

Sincerely,

A handwritten signature in black ink that reads "Jim R. Esquea".

Jim R. Esquea  
Assistant Secretary for Legislation

Attachment

**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES  
(HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT  
ENTITLED, "LONG-TERM CARE HOSPITALS: CMS OVERSIGHT IS LIMITED AND  
SHOULD BE STRENGTHENED" (GAO-11-810)**

Thank you for the opportunity to review and comment on this draft report. GAO examined the extent to which the Centers for Medicare & Medicaid Services (CMS) collects data about long-term care hospital's (LTCHs) quality of care and oversees LTCH survey activities. However, since about 84 percent of LTCHs are surveyed by accrediting organizations (AOs) rather than by CMS or States, a major portion of the study focuses on CMS oversight of AOs, principally The Joint Commission (TJC).

Implementation of the GAO recommendations will further strengthen the consistent improvement in the oversight of accrediting organizations that CMS has undertaken since 2006. A few of the major milestones in this improvement effort are:

***Dedicated Accreditation Team in CMS:*** Beginning in FY 2006, CMS gradually built a small team of professionals in the CMS Survey & Certification Group dedicated to the oversight of AOs.

***More Rigorous Review of AOs:*** AOs must demonstrate that they have standards and survey processes that are equivalent or more stringent than CMS standards for quality of care and safety in order to be approved by Medicare. As a result of more rigorous CMS review, every AO has recently upgraded its standards to ensure such equivalency. CMS also increased the number and extent of reviews to match the 50 percent growth in the number of approved AO programs since FY 2007 (from 12 to 18 programs).

***More Validation Surveys:*** CMS (and States on behalf of CMS) conduct surveys of a sample of facilities after an AO has conducted a survey in those facilities. CMS compares the results of these validation surveys with those of each AO to determine if the AO has missed any deficiencies. The comparison allows CMS to calculate a useful measure of performance (a disparity rate) for each AO. Each year CMS reports these disparity rates to Congress. In recent years CMS has increased the number of such validation surveys from 44 in FY 2004 to 223 in FY 2010.

***Improved Communications:*** CMS instituted annual conferences with all AOs as well as quarterly conference calls, and in FY 2008 implemented a dedicated e-mail address system for each CMS Regional Office for AOs to submit their letters concerning facilities seeking to acquire or retain accredited and deemed status.

***AO Performance Measures:*** In FY 2008, CMS began implementing a system of performance measures for AOs. Results for the major performance measures are reported to Congress each year.

***Oversight of TJC:*** Prior to July 15, 2010, CMS had no jurisdiction over TJC's hospital accreditation program. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), enacted on July 15, 2008, removed the statutory standing of TJC's hospital accreditation program and placed it on the same regulatory footing as all other Medicare-approved AOs. The statute provided a two-year transition period to allow TJC to submit its program for CMS review and receive approval by July 15, 2010. Thus, a major portion of the

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GAO report is focused on a comparatively new CMS oversight responsibility (i.e., the oversight by CMS of TJC).

**Accreditation Organization System for Storing User Recorded Experiences (ASSURE) Database:** In late FY 2009, CMS began implementing a new database designed to improve the accuracy of information regarding the accreditation status of facilities. The new ASSURE Database is currently a desktop application, populated by quarterly electronic data submissions by all 17 of the currently-approved national accreditation programs. In the future, we plan to migrate ASSURE to a web-enabled application.

Much of GAO's report and recommendations focus on data extracted from the ASSURE system. We recognize that ASSURE is very much a work in progress, but also appreciate the GAO's confirmation that this new database offers enormous potential to improve our oversight of AOs and thereby improve oversight of the Medicare-participating health care facilities that are subject to AO jurisdiction.

Despite the progress that CMS has made in the oversight of accrediting organizations, a great deal remains to be done. The GAO recommendations provide good examples of some of the possibilities for improvement. Our response to each recommendation is provided in the material that follows.

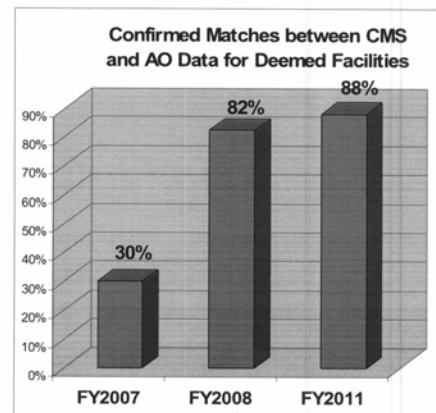
**GAO Recommendation**

*In order to improve the data available on the quality of care at LTCHs, the Administrator of CMS should improve the accuracy of the databases that track LTCH survey results by:*

- a. *Working with AOs and State survey agencies to develop a complete and accurate list of the LTCHs that they each survey and an approach to ensuring that the list is updated in a timely manner.*

**CMS Response**

We concur. Prior to our development and introduction of ASSURE, AOs submitted Excel spreadsheets of their lists of accredited facilities that were deemed to comply with Medicare CoPs. In 2007, we attempted to match the most recent AO Excel facility lists to the data in our database. Only 30 percent of the facilities matched. These dismal results highlighted the fact that there were serious problems in both AO and CMS databases. Clearly the AOs were not identifying their accredited facilities in a manner consistent with the way in which those facilities enrolled in Medicare, i.e., according to the CMS Certification Number (CCN – frequently also called the “Medicare provider number”). Intensive, manual correction and



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reconciliation efforts later managed to raise the match level to 82 percent in May 2008.

These experiences led us to develop the electronic ASSURE database. Under ASSURE there are up-front edits that preclude many of the errors and omissions that were found in the prior Excel spreadsheets. We utilize our ASSURE contractor to run largely automated matching to identify and reconcile discrepancies. The contractor now refers to the AOs (for correction) those discrepancies for which reconciliation is not possible. The graph here shows our progress from FY2007 (when only 30 percent of the facilities matched) to the most recent ASSURE match rate of 88 percent in FY 2011.

The identification of LTCHs in the system presents particular challenges. Such facilities must enroll initially as short-term acute care hospitals and are later converted to LTCHs. This requires a manual notification of the AO by the CMS Regional Office (RO) at the time of conversion. However, starting in FY 2010, the AOs have been receiving quarterly notice from CMS via our ASSURE contractor of errors in their CCN numbers that the contractor was able to correct, and we expect the AOs to make these corrections before submitting their next quarterly data.

We have also begun the process of converting ASSURE to a web-enabled application. This process is expected to take several years to be fully operational. Currently ASSURE is a desk-top application that requires quarterly submissions by the AOs of an updated database that is current as of the date 30 days prior to the quarterly submission. There are a number of serious limitations in this batch mode, desktop application. Once a web-enabled version is implemented we expect to have more flexibility in the database operations and will explore methods to use the enhanced flexibility to increase the accuracy of the database.

It is inevitable that, even with improvements, there may always be some areas of lag or discrepancy between AO and Quality Improvement Evaluation System (QIES)- Certification And Survey Provider Enhanced Reporting (CASPER) data. An AO may, for example, include information on a new facility that it has accredited and which is seeking to enroll in Medicare via accredited deemed status. New facilities in ASSURE are not required to have a CCN number to be entered into the system, since the CCN will likely not have been issued at the time of the AO's data submission. It is possible that that facility might have a significant delay in enrolling in Medicare, or may even have its application rejected, due to a failure to comply with other Federal requirements for enrollment. That facility will not be able to be matched to one in QIES-CASPER, which consists only of facilities enrolled in Medicare (or previously enrolled and terminated).

**GAO Recommendation (continued)**

- b. Expanding the OSCAR database to include the results of all LTCH surveys, such as those conducted by TJC, which are currently stored in the separate assure database.*

**CMS Response**

We agree with the need for a combined database, and plan to accomplish this through an alternate approach. We will extract and merge data from QIES-CASPER and ASSURE into combined spreadsheets.

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OSCAR itself is a legacy system that CMS is phasing out. The successor to OSCAR is the Quality Improvement Evaluation System (QIES), which consists of a suite of complex applications. A major component of 'QIES' is the Automated Survey Processing Environment (ASPEN), which is housed on separate servers in each state to support State Survey Agency and CMS RO daily operations. The QIES system also houses patient-level data submitted by long-term care facilities (the Minimum Data Set (MDS)) and home health agencies (the Outcome and Assessment Information Set (OASIS)). CASPER is the national data repository that supports QIES, and contains a more limited amount of data extracted on a daily basis from the State ASPEN servers. There are clear disadvantages to an effort to merge ASSURE and ASPEN, since the business requirements for ASPEN are far more extensive and reflect the certification and other functions that ASPEN supports in addition to capturing survey results for States and CMS. In addition, neither ASPEN nor CASPER is presently a web-based application, and integrating ASSURE into ASPEN would impair or prevent our attempts to web-enable ASSURE due to security concerns.

**GAO Recommendation**

*In order to improve the data available on the quality of care at LTCHs, the Administrator of CMS should improve information sharing with TJC regarding complaint validation survey results for TJC-surveyed LTCHs, such as ensuring that all survey findings are shared in a timely fashion.*

**CMS Response**

We concur. We intend to reinforce existing CMS policy on sharing of information with AOs, including AOs that accredit LTCHs. Current CMS policy calls for CMS ROs to copy the applicable AO on their correspondence to the accredited hospital communicating survey results and, if applicable, enforcement actions. We will clarify the existing policy for the ROs and work with them to enhance compliance.

**GAO Recommendation**

*In order to improve CMS' oversight of survey activities at LTCHs, the Administrator should conduct traditional validation surveys at a sample of LTCHs each fiscal year and include a LTCH disparity rate in its annual financial report to Congress.*

**CMS Response**

We concur. The primary purpose of a traditional validation survey is to assess the survey process utilized by an AO through the calculation of a disparity rate between findings of AO and SA surveys of the same health care facilities within a 60-day timeframe. Between FY 2006 and FY 2009 the number of LTCHs that were included in the traditional validation sample assigned to SAs ranged between 4 and 8 LTCHs per year. We will explore an option that would allow us to increase our traditional validation survey sample for hospitals, thereby permitting the inclusion of a stratified sample of LTCHs each year.

For FY 2011, we assigned the SAs to conduct non-traditional validation surveys on a representative sample of approximately 34 LTCHs, without regard to the AOs' survey schedules. We needed to disregard the AO survey schedule in order to ensure that we would have a large enough sample to compare LTCH survey results with those for non-accredited LTCHs, as well as to hospitals in

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general. The results of these surveys will assist us in making further plans with respect to this GAO recommendation.

**GAO Recommendation**

*In order to improve CMS' oversight of survey activities at LTCHs, the Administrator should explore differences in survey workload and in the resources survey organizations devote to LTCH surveys in order to:*

- a. Identify areas for efficiencies, and*
- b. Determine whether the workload associated with complaint validation surveys could be more equitably shared with TJC.*

**CMS Response**

We concur. This is an area that definitely merits exploration. Meanwhile, we will work with the CMS ROs to clarify (for consistent national application) the policy for triaging complaints for deemed facilities, and the policy for referring to the appropriate AOs those complaints that do not allege substantial noncompliance with one or more CoPs.

**GAO Recommendation**

*In order to improve CMS' oversight of survey activities at LTCHs, the Administrator should develop a plan to use available data on survey activities to hold survey organizations accountable for conducting surveys consistent with CMS requirements for evaluating the quality of care provided by LTCHs.*

**CMS Response**

We concur. We will review the various data available to us to determine to what extent it can be used to develop and subsequently implement additional AO performance measures for evaluating quality of care at hospitals, including LTCHs.

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# Appendix III: Comments from The Joint Commission

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August 24, 2011

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

Dear Ms. Kohn:

The Joint Commission appreciates the opportunity to provide formal comments on the report, *Long-term Care Hospitals: CMS Oversight is Limited and Should Be Strengthened*. Long-term care hospitals (LTCHs) occupy an extremely important role in the United States' health care delivery system. These hospitals specialize in delivering care to critically-ill patients who have highly complex medical conditions. Therefore, ensuring that these organizations provide safe, high-quality health care is of utmost importance.

The Joint Commission takes seriously its responsibility to evaluate the quality and safety of the care provided by America's health care organizations. Since its founding in 1951, The Joint Commission has been the leader in developing the highest standards for quality and safety in the delivery of health care, and for evaluating organization performance based on these standards. Today, more than 19,000 health care organizations and programs use Joint Commission standards to guide how they administer care and continuously improve performance. Importantly, The Joint Commission evaluates health care organizations across the continuum of care, including most of our Nation's hospitals. Also in the family of Joint Commission accredited entities are clinical laboratories, ambulatory care and office-based surgery facilities; behavioral healthcare organizations; home care; hospice; long term care organizations; and durable medical equipment suppliers. Although accreditation is voluntary, the federal government and most state regulatory bodies recognize and rely upon Joint Commission accreditation evaluations and decisions for their certification or licensure purposes.

Overall, The Joint Commission agrees with the GAO's recommendations to improve the accuracy of the databases that track LTCH survey results and improve information sharing with The Joint Commission regarding complaint survey results. There is value in having accurate, complete and timely data to inform policy and management decisions and to evaluate organizational performance. Other government initiatives that are underway or planned, such as implementing an LTCH quality measure reporting system and developing LTCH-specific conditions of participation, which the GAO's November 2010 report cited as a CMS priority, will contribute greatly to improved oversight. The Joint Commission welcomes strengthening its oversight partnership with CMS on quality and safety performance of Medicare certified organizations.

The Joint Commission questions the conclusion that CMS oversight of LTCHs is limited; a more accurate conclusion might be that CMS oversight of LTCHs is not separated in a focused manner from that of other hospitals. Currently, accountability for LTCH quality of care and patient safety falls under the well-established acute care hospital oversight framework. While LTCH-specific quality measures and LTCH-specific conditions of participation would improve the existing framework, the value of LTCH-specific validation surveys as the GAO recommends is questionable on methodological, resource allocation, and validity grounds. For instance, stratifying the annual validation sample to include a representative number of LTCHs, or any other type of specialty hospital, as part of the annual validation survey schedule would require a significant increase in the federal budget allocated to validation surveys in order to arrive at a statistically valid sample size that would in turn support an LTCH specific disparity rate calculation. As an alternative to stratifying the validation sample, CMS could maintain complaint survey data by hospital specialty type and monitor this information to determine

when the need may arise to perform additional focused oversight surveys of LTCHs. This would be less costly and just as effective. Furthermore, SA performance of survey activities has come under criticism, particularly the wide variation in the number and severity of deficiencies cited by different SAs.<sup>123</sup> This raises questions as to whether validation surveys by SAs, as currently conducted, are the most appropriate measure of AO performance of Medicare related survey activities.

As noted in the report, The Joint Commission conducts surveys on a 3-year interval; in contrast, State Survey Agencies (SAs) conduct routine surveys every 3 to 5 years, likely due to resource constraints. The Joint Commission is concerned that SA surveys for non-accredited hospitals extends beyond 3 years.

We strongly agree with the GAO recommendation to use existing data to improve oversight of LTCH quality of care. To accomplish this, SA triaging of complaints needs improvement. For example, the report reveals that only 6 percent of SA-conducted complaint surveys identify one or more condition-level deficiencies, 66 percent did not cite any deficiencies, and two State Survey Agencies accounted for nearly half of all complaint surveys and cited almost no condition-level deficiencies. This is consistent with GAO and OIG analyses about the inconsistency of SA citation of deficiencies. It is difficult to avoid the conclusion that federal dollars are not being well spent to continue the current approach to conducting onsite complaint investigations. In contrast, The Joint Commission's complaint triage approach, which considers a number of factors including the information contained in the complaint itself, and previous SA and Joint Commission survey findings, prioritizes on-site evaluations for only those allegations that could pose high risk to patient safety and quality of care. This approach has yielded complaint substantiation rates that range between 50 percent and 93 percent annually. Since this approach relies heavily on accurate and timely information, we would like to underscore our agreement with the GAO recommendation that SAs share survey findings with The Joint Commission in a consistent and timely manner. Working together, The Joint Commission and CMS can forge a better public-private oversight framework for LTCHs, by leveraging our respective activities.

While the GAO analysis identifies important areas for improvement, there are areas where strides have been made to improve oversight of health care providers and AOs. One such area involves the ASSURE database. With the fairly recent implementation of ASSURE in October 2009, CMS was able for the first time to systematically collect and compile survey data from all AOs. All AOs with deeming authority now record their accreditation activities and enforcement actions in the same database in a standardized manner. Prior to ASSURE, each AO submitted an Excel spreadsheet that contained different information about providers. Therefore, while improvements to ASSURE are still necessary, as the GAO analysis reveals, it is important to applaud CMS for developing ASSURE and evaluating and updating it on an ongoing basis to improve the accuracy and relevance of the information.

Throughout the report, the GAO notes that "CMS does not have data on the results of surveys conducted by TJC prior to 2009...." While The Joint Commission did not report at the level of specificity that included survey findings (i.e., requirements for improvement or RFIs) prior to implementation of ASSURE in 2009, we did provide to CMS the outcome of surveys (i.e., accreditation status), demographic information, and up-to-date survey schedules. Providing information at the RFI level was not possible prior to the Medicare Improvements

<sup>1</sup> Government Accountability Office. *Nursing Homes: Addressing the Factors Underlying Understatement of Serious Care Problems Requires Sustained CMS and State Commitment* (GAO-10-70). Washington, D.C.: November 2009.

<sup>2</sup> Government Accountability Office. *Nursing Homes: Federal Monitoring Surveys Demonstrate Continued Understatement of Serious Care Problems and CMS Oversight Weaknesses* (GAO-08-517). Washington, D.C.: May 2008.

<sup>3</sup> Office of Inspector General, US Department of Health and Human Services. *Nursing Home Deficiency Trends and Survey and Certification Process Consistency* (OEI-02-01-00600). Washington, D.C.: March 2003.



for Patients and Providers Act of 2008, when a crosswalk that related Joint Commission Standards to the Medicare hospital conditions of participation was not required (and did not exist). Therefore, The Joint Commission urges the GAO to reevaluate its use of this statement throughout the report and ensure that the report reflects the full context of the reporting landscape prior to implementation of ASSURE in 2009.

Another area where recent and promising strides have been made to improve oversight of LTCHs involves steps toward implementing LTCH quality measures. The report notes that CMS does not have quality measures for LTCHs, but will do so beginning in 2014. Prior to enactment of the Patient Protection and Affordable Care Act (PPACA), which requires LTCH quality reporting by 2014, The Joint Commission initiated efforts to develop such measures. Since then, CMS with The Joint Commission and other stakeholders have taken concrete steps toward adoption of LTCH-relevant measures. Much work is yet to be done, especially related to ensuring that any process measures that are adopted meet The Joint Commission's criteria for "accountability" measures. The Joint Commission is strongly urging CMS to adopt this classification system for determining which process measures should be reported by LTCHs. Accountability measures are defined according to the following four criteria:

**Research:** Strong scientific evidence exists demonstrating that compliance with a given process of care improves health outcomes (either directly or by reducing risk of adverse outcomes).

**Proximity:** The process is closely connected to the outcome it impacts; there are relatively few clinical processes that occur after the one that is measured and before the improved outcome occurs.

**Accuracy:** The measure accurately assesses the most critical process components. That is, if the measure construct does not support data capture and assessment of the most essential process components, it is a poor measure of quality, likely to be subject to workarounds that induce unproductive work instead of work that directly improves quality of care.

**Adverse Effects:** The measure construct is designed to minimize or eliminate unintended adverse effects.

In conclusion, The Joint Commission believes there is room for improvement in CMS's oversight of the quality of care provided by LTCHs and their oversight of survey activities. However, it is also important to recognize the positive strides CMS has already taken toward these goals. Importantly, if we are to have a more effective oversight framework in an environment of limited resources, one must prioritize those oversight activities that are more likely to achieve desired results such as 1) improving communication and information exchange; 2) using appropriate, reliable, and valid quality measures; and 3) effectively triaging complaints and using the results of complaint surveys to determine the need to modify the validation sampling methodology. This approach of leveraging existing and ongoing activities is likely to be more effective and is sensitive to the resource constraints of the current environment.

We appreciate the opportunity to review and comment on this report. If you have any questions, don't hesitate to call me or you may contact Margaret VanAmringe, Vice President for Public Policy and Government Relations, at (202) 783-6655.

Sincerely,



Mark R. Chassin, M.D., M.P.P., M.P.H.  
President  
The Joint Commission

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# Appendix IV: GAO Contact and Staff Acknowledgments

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## GAO Contact

Linda T. Kohn (202) 512-7114 or [kohnl@gao.gov](mailto:kohnl@gao.gov)

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## Staff Acknowledgments

In addition to the contact name above, Walter Ochinko, Assistant Director; Sarah Harvey; Kristin Helfer Koester; Dan Lee; Elizabeth T. Morrison; Phillip J. Stadler; and Jennifer Whitworth made key contributions to this report.

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