

medicaid
and the uninsured

June 2002

**Nursing Home Quality:
State Agency Survey Funding and Performance****Charlene Harrington, University of California, San Francisco**

Those with long-term care needs are among the most vulnerable in our society. People who live in nursing homes are often there as a last resort, unable to care for themselves and relying on others to meet their most basic needs. For over 30 years, the quality of nursing home care has been a major public policy concern in the United States. In 1987, following the publication of a highly critical Institute of Medicine report, Congress passed major nursing facility regulation in the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987). The Centers for Medicare and Medicaid Services (CMS)—formerly the Health Care Financing Administration (HCFA)—gradually implemented the OBRA 1987 reforms between 1988 and 1995, but quality problems still persist today. A major focus of recent Congressional inquiry and investigation has been the effectiveness of state survey agencies and their ability to monitor nursing home quality and enforce federal regulations.

This policy brief describes the resources, staffing, and performance of state licensing and certification agencies based on findings from a survey of state survey agency officials.¹ There is wide variation across the states in funding and performance. A complex set of factors, including funding, influences individual state performance.

Federal Financing and Regulation of Nursing Home Care

Public Financing of Nursing Home Care. Public health care programs are a significant financing source for this country's nursing home care. Medicaid pays for nearly half of all nursing home expenditures.² In 2000, Medicaid spent \$44 billion on nursing home care and \$6 billion on home and community based care. Medicaid spending on long-term care has increased by over \$20 billion since 1990, a trend that is expected to continue in the future. Medicare plays a more limited role in financing nursing home care, accounting for only 10 percent of total spending. As a result, nursing facilities—95 percent of which are certified for either Medicaid or Medicare—rely heavily on public financing as a revenue source.

Conditions for Participating in Medicare and Medicaid. The Social Security Act requires nursing facilities participating in the Medicare and Medicaid programs (i.e., receive Medicare and Medicaid payments for services provided to Medicare and Medicaid beneficiaries) to meet certain requirements.³ These requirements are called conditions of participation and are specified in law and regulation. The framework for today's nursing

facility conditions of participation was enacted as part of OBRA 87.

OBRA 87 increased the statutory requirements for nursing facilities participating in Medicare and Medicaid. It strengthened quality standards, the survey process, and the enforcement mechanisms for nursing facility regulation. It also mandated uniform comprehensive assessments for all nursing facility residents and required the survey process to focus on resident outcomes.⁴ Getting all the requirements in place has been a slow process. CMS took three years to put into operation the regulations to implement OBRA 87 and seven years to implement the regulations needed to put its regulatory enforcement mechanisms in place.⁵

Regulatory Structure. CMS is responsible for developing and maintaining federal regulatory requirements, but the actual work of observing whether facilities meet federal requirements is done by states through contracts with the federal government. This process is referred to as "survey and certification." It is the government's opportunity to spend time (about five days) at least once a year inside a facility reviewing its procedures and records, and observing residents' quality of care and quality of life.

State survey agencies are responsible for licensing nursing facilities according to state legal requirements, certifying the facilities that meet the Medicare and Medicaid conditions of participation and investigating complaints about poor quality care. When state surveyors find that a nursing facility does not meet federal requirements, they issue a citation called a deficiency. Deficiencies can range from minor and isolated violations to major and widespread problems. Penalties correspond to the level of deficiency --- from requiring the nursing facility to provide a plan of correction to denying payment or imposing Civil Monetary Penalties (CMPs).

While the federal nursing facility regulatory system is decentralized and relies on state agencies for first-line regulatory activities, federal law requires CMS to oversee state survey agency performance. The law requires the Department of Health and Human Services (DHHS) to conduct validation surveys on at least five percent of the number of nursing facilities surveyed by the state in the year, but in no case less than 5 nursing facilities in the state. If DHHS finds that a state has failed to perform surveys or that the state's performance is inadequate, DHHS can provide training to the state survey agency staff or

reduce Medicaid payments to the state.⁶

1998 GAO Studies and Federal Nursing Home Initiative

In response to concerns that state surveyors were finding too few deficiencies and applying too few sanctions, the General Accounting Office (GAO) conducted a 1998 study of the federal and state enforcement programs in California.⁷ The GAO reported to Congress that, "nursing homes have not been and currently are not sufficiently monitored to guarantee the safety and welfare of their residents." One of the most serious findings from the study was that state surveyors were often unable to detect serious quality of care problems.⁸ The GAO concluded that CMS policies were not effective in ensuring that deficiencies are identified, corrected, and remain corrected. The GAO found that CMS and the states allowed most facilities to correct violations without penalties. Only a few facilities were terminated from the program and most of these were later reinstated and continued to have violations.

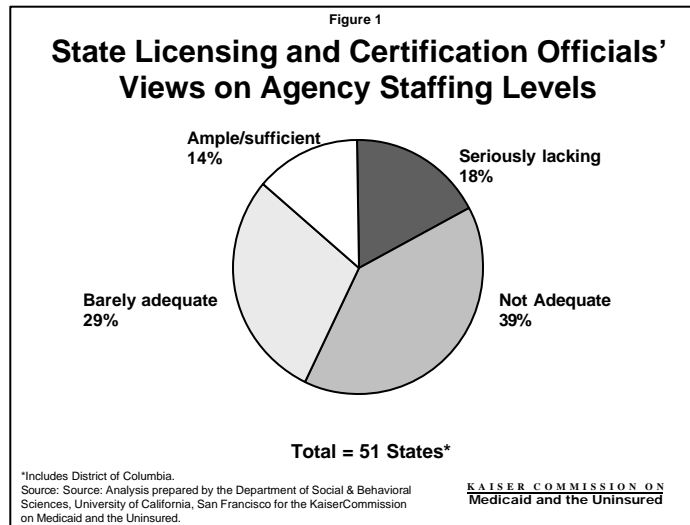
In 1998, the U.S. Senate Special Committee on Aging began hearings on the GAO's findings, and CMS implemented the Nursing Home Initiative to strengthen regulatory enforcement and expand the oversight of state inspections.⁹ The goal of this initiative was to increase the finding of deficiencies, and to ensure that penalties are meaningful and ultimately improve care quality. In addition, CMS also issued new guidelines for the imposition of Civil Monetary Penalties (CMPs).

State Survey Agency Staffing

State survey agencies use much of their resources to employ agency staff. In the survey of state certification agencies, states report that they employed 2,999 full-time-equivalent (FTE) surveyors in 2000 (71 percent were qualified nurses). This translates to about one FTE surveyor for 611.8 nursing facility beds, or one FTE for every 5.7 nursing facilities in 2000. States also report high turnover rates among survey staff --- some as high as 40 percent. The main reason given was the low average entry-level salary for qualified nurse staff of \$36,017 and for non-nurse staff of \$33,416. Twenty-nine states cited low salaries as a barrier to recruitment, while other states reported that the current shortage of registered nurses is an important barrier. Other reported barriers include amount of travel,

requirement for weekend work, evening and night work for staggered surveys, and the stressful and sometimes adversarial nature of the regulatory process.

As a result, only 7 states said they had ample or sufficient staff to fulfill their licensing and certification function, while 15 indicated that current staffing levels were barely adequate. The largest group – 20 states – reported that staffing was not adequate and an additional 9 states described current staffing levels as seriously lacking (Figure 1).



State Survey Agency Reactions to Recent Changes

The 1998 Nursing Home Initiative required states to implement new survey procedures that would enable surveyors to detect more deficiencies. They include using staggered surveys (scheduled on weekends, holidays or nights); making survey dates less predictable; conducting timely complaint investigations; targeting the poorest performing facilities for frequent monitoring and surveys; tracking changes in owners and poor performing facilities; ensuring the accuracy of resident assessment data; using CMS quality indicators to target potential facility problems; and submitting survey results data in a timely fashion.

New Survey Procedures. According to the results of the survey of state certification agencies, states have reported problems implementing the 1998 initiative. First, despite increases in federal funding following the 1998 initiative, states generally report insufficient resources and staff to adequately implement several of the 1998 reforms. For example, states report staggering only about 5 percent of their surveys. Second, state survey

agencies report that CMS is too prescriptive about which facilities they must target for additional surveys. As a result, the majority of states considered the targeted surveys to be a waste of limited resources. Finally, 20 percent of the agencies reported they were not using the quality indicators because they lacked the resources or trained staff.

Civil Monetary Penalties. In 1999, CMS attempted to improve states' flexibility to impose federal CMPs --- thereby strengthening enforcement of nursing home regulations. The new guidelines allow CMS to impose federal CMPs for the number of days a facility is out of compliance or for each instance that a facility is not in substantial compliance. The new guidelines give states the option to impose federal CMPs when a noncompliance results in actual harm to the resident. For more serious noncompliance that constitutes immediate jeopardy, the guidelines require states to impose federal CMPs.

Despite the new 1999 guidelines, few state survey agencies consider the imposition of federal CMPs to be effective in bringing facilities into compliance with regulations. About 16 states have their own state CMP systems and almost all consider their state system to be more effective than the federal CMPs because they are easier and faster to use. State survey agencies cited problems with the federal remedy: CMS sets the fines too low, CMS does not pursue collecting the fines, and the CMS process is bogged down by a complicated appeals process.

Other Enforcement Tools. In addition to CMPs, states may rely on other enforcement tools such as denying payment for new admissions, imposing temporary management, and terminating the facility's participation in Medicare and Medicaid. The most common of these is denying new payment for new admissions. In 1999, 32 state survey agencies reported using denial of payment (either Medicaid or Medicare) for new admissions in 1,454 facilities, and all states (except Utah) rated the denial of payments as an effective intermediate sanction. Only nine state survey agencies reported using some type of temporary manager for 38 facilities in 1999. Seventeen agencies reported issuing 46 decertification or termination notices for the Medicare and/or Medicaid programs. However, all but seven were later recertified.

Who Pays for Survey and Certification Activities?

Since both Medicare and Medicaid finance nursing home care, the programs also share the costs associated with survey and certification activities. The following describes how each program finances survey and certification.

Medicare. In 1999, CMS authorized \$198 million to states for survey and certification of all Medicare providers.¹⁰ Of the funds CMS authorizes states to spend on Medicare survey and certification, states spend about 75 percent on long-term care survey and certification.¹¹ CMS considers a variety of information in determining how to allocate survey and certification funds among the states.¹² First, CMS considers each state's spending trend and the amount it has historically budgeted for all Medicare survey activities --- long-term care and other provider types. CMS also considers whether a state's survey workload has changed significantly (i.e., new facilities in the market). Finally, in an effort to reward efficient states, CMS also takes into consideration the state's average time surveying a facility (not counting travel time). CMS compares this information to the national average to better understand how a state is allocating resources.

Medicaid. The Medicaid funding mechanism is significantly different from Medicare. Since states administer the Medicaid program, the federal government has little control over the amount of Medicaid funds that are spent on survey and certification. Within federal statutory and regulatory guidelines, states determine how much to spend on Medicaid benefits and administrative costs. The federal government then matches these state Medicaid expenditures. There is no limit on the amount of federal matching funds a state can request --- as long as the state's Medicaid expenditures are consistent with the federal rules. The federal contribution varies depending on the type of expenditure. For every dollar spent on survey and certification activities, the federal government pays 75 percent and the states pay 25 percent.¹³

When a facility is certified for both Medicare and Medicaid, the two programs share the cost of surveying the facility.¹⁴ The state agency divides the survey costs according to the percentage of beds that are Medicare and those that are Medicaid. For example, in a 100 bed facility where 50 beds are Medicare-certified and 50 beds are Medicaid-certified, the Medicare and the Medicaid program each pay half of the survey costs for that facility.

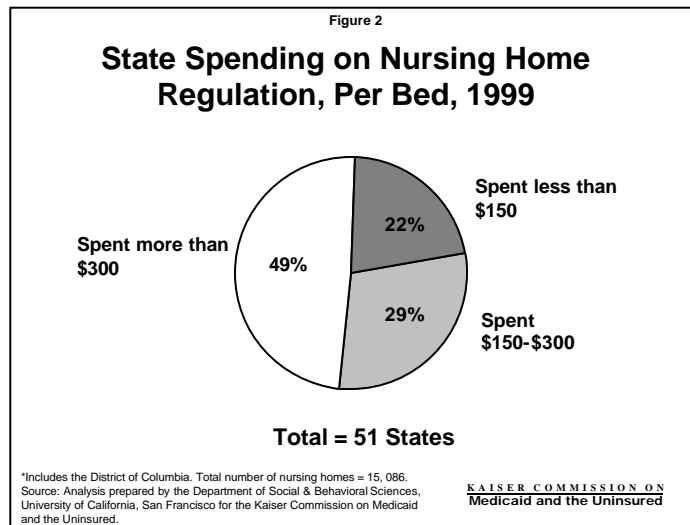
Medicare survey and certification spending growth was relatively low until the HCFA Nursing Home Initiative of 1998. U.S. Congressional funding increases following this initiative increased the average annual growth rate in Medicare spending to about 10 percent. In contrast, states did not increase Medicaid spending on survey and certification between 1995 and 2000. Therefore, the average annual increase in combined Medicare and Medicaid funding for survey and certification was only five percent from 1995 to 2000.

State-Only Spending. In the survey of state certification agencies, states survey agencies reported spending an additional \$98 million of state-only funds (non-matchable through Medicaid) on other survey activities in 2000. About two-thirds of this amount was financed through state general funds and one-third through licensing fees and other sources. There are several possible reasons these funds did not qualify for federal matching funds. First, many states have licensure requirements that go beyond the federal rules. States must spend their own funds on survey activities related to state-specific licensure requirements. Second, when Medicare survey and certification spending growth was flat, some states complained to CMS that they had to supplement federal funds with state funds. This state supplemental spending may not have qualified for federal matching dollars under Medicaid because it was a Medicare activity. Adding state-only spending in 2000 (\$98 million) to the state portion of Medicaid (\$37 million) increases the state share of total survey and certification spending to about 35 percent.

Total Spending. Spending on survey and certification accounts for an extremely small share of total long-term care spending. In 2000, total expenditures for long-term care survey and certification activities were about \$382 million. However, this spending is less than one half of one percent (.4%) of total spending on nursing home care in the country in 2000, about .7 percent of the total government spending on nursing home care. It translates into only about \$22,433 per nursing facility for regulatory activities --- less than half the average cost of one year of care for one resident.

Variation in State Spending. Total national spending masks the large degree of variation in spending by states. The survey of state certification agencies reveals that while state spending is about \$208 per bed on average, some states spend over eight times as much per bed as others. Per bed spending ranges from a low of \$94 in West Virginia to a high of \$770 in Alaska (a special case because of its large geographical area). Overall, 15 (29%)

states reported spending less than \$150 per bed, while 11 (22%) states reported spending more than \$300 per bed (Figure 2). Differences in geography, economies of scale in larger states, and differences in the nature and extent of state-level regulations might explain some of this variation. The variation also reflects differences in state willingness to spend money on survey activities.



State Survey Agency Views on Funding Levels. In the survey of state certification agencies, many states report not having sufficient resources to carry out the scope of licensing and certification activities that has been increasing as a consequence of the 1995 regulations and the 1998 initiative. Overall, 37 state agencies reported that their current level of federal resources was not adequate to meet CMS' certification requirements and 23 said that their state resources were insufficient to undertake state licensing requirements. About 20 state survey agencies reported that their legislatures or administrations are reluctant to spend money on survey and certification because they are either not supportive of regulation, want to limit state employees, or do not want to make the matching contribution for Medicaid.

These state-level attitudes make the process for getting state funding slow and difficult. Some states said lack of funding particularly hurts their ability to investigate quality complaints and monitor nursing facilities at the rate required by law. Almost half of the state survey agencies report that inadequate funding leads to inadequate staffing.

Measuring State Survey Agency Performance

States vary greatly in their performance of monitoring and enforcement of nursing home quality. Tables 1 and 2 show summary statistics on two sets of state performance indicators from the survey results. The first (Table 1) set of indicators measures how well a state performs its basic nursing facility monitoring duties (i.e., conducting nursing facility surveys within the required time frame, investigating complaints). Table 2 measures how stringently states enforce the law once they are inside the facility (i.e., issuing deficiencies and CMPs). State performance varies extremely across both types of indicators. The following is a description of this variation and possible explanations.

Performance Indicators: Monitoring. State survey agencies are required to conduct surveys annually but no less frequently than 18 months. They are also required to conduct more frequent surveys of certain poor performing facilities and to investigate complaints. A method for measuring state performance is to determine how well survey agencies are meeting these requirements and how frequently they are monitoring facilities.

As Table 1 (following page) shows, state monitoring of nursing facilities varies a great deal. The least amount of variation occurs for the average time between surveys and the percent of complaints investigated. The average time between surveys is about 287 days --- with a low of 211 in Louisiana to a high of 478 in Maryland.¹⁵ The most variation occurs in the percentage of surveys conducted more than 18 months after the last survey. States report an average of about 4 percent of all surveys occurring outside the 18-month window. In some states, such as Maryland (34%), Arizona (24%), and Washington, DC (15%), the percentage of late surveys was much higher than the average of 4 percent.

Table 1: Indicators of State Monitoring Performance, 1999

Monitoring Indicators	Average	Lowest	Highest
Average # of Days Between Surveys	287	211	478
Percentage of Surveys Conducted more than 18 Months after Last Survey	4	0	34
Percentage of Complaints Investigated	79	37	100
Average Number of Complaints Investigated Per 100 Beds	3	1	13

Source: Analysis of CMS On-Line Survey Certification and Reporting (OSCAR) system prepared by the Department of Social & Behavioral Sciences, University of California, San Francisco for the Kaiser Commission on Medicaid and the Uninsured.

Performance Indicators: Enforcement. Once inside a facility, some state survey agencies more stringently enforce nursing facility regulations than others. More stringent states find more deficiencies overall and more facilities with deficiencies. They find more facilities causing harm or jeopardy and issue more CMPs per facility.

Table 2 shows that enforcement performance also varies a great deal across states. For example, states report an average number of 5.4 deficiencies per facility.¹⁶ On average, states report that 18 percent of the surveyed facilities had no deficiencies but the standard deviation for this measure was almost 11 percent. Therefore, a state’s percentage could be reasonably expected to fall anywhere between 7 and 29. Table 3 shows the overall ranking of states according their score across five enforcement indicators similar to those displayed in Table 2.

Table 2: Indicators of State Enforcement Performance, 1999

Enforcement Indicators	Average	Lowest	Highest
Average Number of Deficiencies per Facility	5	2	11
Percentage of Surveyed Facilities with No Deficiencies	18	2	49
Percentage of Surveyed Facilities with Significant Deficiencies (G or Above)*	26	6	54
Average Number of CMPs Per Facility	0	0	1

* Deficiencies are serious and have caused or have the potential to cause harm or immediate jeopardy to resident health and safety.

Source: Analysis of CMS On-Line Survey Certification and Reporting (OSCAR) system prepared by the Department of Social & Behavioral Sciences, University of California, San Francisco for the Kaiser Commission on Medicaid and the Uninsured.

Table 3: Selected State Enforcement Indicators and Ranks in 1999

State	Facilities		Enforcement Indicators					Rank Scores	
	Total # of		Average # of Deficiencies per Facility 1999 OSCAR	Percent of Facilities			Avg. CMPs Issued per Facility Surveyed 1999 HCFA	Average Rank Score for All 5 Indicators	Overall Rank
	NH Facilities Certified 1999 HCFA	Facilities Surveyed 1999 HCFA		with Deficiencies 1999 OSCAR	Cited for Harm or Jeopardy 1999 HCFA	Cited for Sub-Standard Care 1999 HCFA			
US	16,970	15,724	5.7	82.5	31.0	5.1	15.2		
WA	277	272	9.7	98.5	59.8	6.3	16.2	7.3	1
AR	272	213	7.4	93.5	31.4	14.1	31.9	8.2	2
CA	1,369	1,148	11.3	95.8	31.3	6.4	72.7	9.1	3
OR	150	137	6.8	81.0	58.8	17.6	97.8	9.4	4
ID	84	82	7.3	91.0	57.3	8.5	9.8	10.5	5
SC	178	149	8.3	95.2	29.7	8.8	12.1	11.0	6
MI	439	398	9.9	97.0	47.4	6.7	5.5	11.6	7
AL	225	201	7.4	92.9	43.0	4.0	27.9	11.9	8
IN	566	539	7.4	89.7	24.5	7.5	44.5	14.6	9
KY	308	285	7.3	91.1	29.1	8.4	9.8	15.7	10
KS	393	417	6.1	85.7	43.0	6.3	15.3	16.0	11
NV	51	40	11.4	92.5	23.8	4.8	25.0	16.4	12
AZ	151	85	7.1	90.8	39.3	3.6	12.9	17.0	13
IL	869	874	6.1	89.5	32.3	3.7	79.1	17.2	14
AK	15	16	6.1	92.9	37.5	12.5	0.0	17.3	15
DE	43	36	7.2	82.3	50.0	5.6	5.6	18.1	16
NC	412	391	5.7	81.4	47.4	3.1	17.4	20.3	17
OH	1,013	819	5.3	79.7	30.3	7.1	14.4	20.6	18.5
FL	732	730	6.5	89.1	30.1	7.3	5.1	20.6	18.5
MS	193	184	5.6	86.8	31.3	5.5	9.8	21.1	20
NM	80	79	5.1	79.2	29.5	7.7	11.4	22.1	21
TN	352	352	4.6	85.3	23.9	4.3	17.9	25.2	22
MT	104	103	5.4	92.8	43.7	1.0	1.9	25.6	23
NH	83	68	3.9	66.7	35.3	7.4	11.8	26.0	24
GA	363	360	4.4	81.3	30.0	4.2	10.0	26.3	25
MO	552	524	5.1	79.3	25.7	6.7	5.7	27.2	26
HI	45	41	6.7	92.3	17.1	4.9	0.0	27.5	27
ND	88	87	5.0	87.4	37.6	3.2	1.1	27.6	28
ME	126	129	3.3	75.4	20.5	7.6	47.3	28.1	29
WV	141	137	5.5	89.5	27.0	2.9	3.6	28.6	30
CT	259	246	4.0	87.4	60.1	3.2	0.0	28.7	31
TX	1,236	1,212	4.5	77.6	23.9	5.4	9.4	30.3	32
SD	114	88	4.7	89.4	37.5	1.1	0.0	30.7	33
PA	772	791	4.1	81.2	32.3	1.9	8.8	31.0	34
MN	434	429	3.7	78.4	34.2	3.8	3.0	31.9	35
MD	261	140	2.8	58.2	29.2	7.6	7.9	32.6	36
WY	40	38	4.7	88.9	26.3	2.6	0.0	33.6	37
MA	526	478	4.1	67.5	33.2	3.4	1.9	35.2	38
IA	469	420	4.1	79.4	24.2	2.3	7.1	35.2	39
UT	93	80	3.5	77.0	16.5	3.8	11.3	35.2	40
WI	420	415	3.4	73.5	17.9	1.9	68.4	36.0	41
OK	396	353	4.2	68.7	14.4	4.2	8.2	36.3	42
NY	668	573	3.4	75.1	27.0	3.5	5.4	36.8	43
LA	338	341	4.5	72.6	22.6	3.9	0.0	38.0	44
NE	236	232	3.5	76.1	29.6	2.2	0.9	38.9	45
NJ	361	314	2.0	51.5	26.5	4.7	1.9	39.8	46
VT	44	49	2.1	54.8	14.3	2.0	10.2	40.8	47
VA	285	280	3.6	69.2	19.6	2.5	2.9	41.8	48
RI	99	98	3.1	71.7	15.0	4.0	0.0	42.6	49
DC	20	15	4.3	78.6	0.0	0.0	0.0	43.1	50
CO	225	236	2.8	72.1	10.3	1.7	3.4	45.1	51

Source: Analysis prepared by the Department of Social & Behavioral Sciences, University of California, San Francisco for the Kaiser Commission on Medicaid and the Uninsured.

Barriers to Enforcement. In the survey of state certification agencies, states identified many barriers to enforcement related to the current federal enforcement procedures. These include inconsistencies in the central and regional office staff procedures and policies, delays necessitated by having to request approval from CMS to impose the intermediate sanctions, delays in CMS processing of intermediate sanctions, and concern that intermediate sanctions do not go into effect immediately. The states cite poor communications between CMS and the states, lack of information from CMS about the intermediate sanctions and the appeals process, CMS delays in the appeal procedures, and that CMS procedures are too prescriptive. States express frustration with the decertification process because facilities can reenter the program too quickly. States want more federal training for surveyors in the survey process. These concerns about CMS enforcement procedures resulted in at least 20 states using their own state intermediate sanction procedures, rather than the federal process because they believe the state procedures are more effective.

State Enforcement Performance Predictors. Certain state characteristics may predict how highly states rank in enforcement stringency. A regression model examined the following potential predictors of state stringency: the percentage of the state population over age 85, the governor's political affiliation, the percentage of facilities that are part of company chains, the percentage that are hospital facilities, the occupancy rate, and the number of beds per 1000 elderly people in the state. This equation found that having a large age 85 and older population and a Democratic governor predicted a higher stringency ranking --- possibly because larger elderly populations advocate for enforcement stringency and the Democratic party is more inclined to support regulation. However, states with high occupancy rates and a large number of beds predicted a lower stringency ranking. High occupancy rates may reflect reluctance among state regulators to impose strict penalties or close facilities if few other beds are available. A large number of beds may reflect nursing home industry strength.

Relationship Between Spending and Performance. There appears to be a relationship between greater spending on survey activities and greater likelihood of deficiencies. In an analysis of potential predictors of agency performance, spending per bed is a significant predictor of the average number of deficiencies per facility and the percentage of facilities with major deficiencies (see Appendix A). Spending per bed is not a significant predictor of

the other performance indicators listed in Tables 1 and 2.

Summary and Implications

In recent years, Congress has increased its appropriation of federal funding for survey and certification. However, the lack of growth in state spending has resulted in overall (combined federal and state) funding increases of only about 5 percent annually from 1995 to 2000. As a result, survey agencies report lacking funds necessary to adequately staff their agencies and conduct surveys.

Lack of funding can explain some part of the alarmingly wide variation in state survey agency performance. However, variation in performance also reflects differing attitudes among individual states towards regulation. Some states limit nursing facility regulation by imposing state hiring moratoriums, funding caps, agency staff limits and poor compensation for survey agency employees. These types of limits --- imposed by state legislatures and administrations --- may even prevent a state from spending the federal funds authorized by CMS. Therefore, state attitudes may often be as much of an obstacle to high survey agency performance as inadequate funding.

Another barrier to enforcement states identified is the cumbersome bureaucratic enforcement process. The states wanted improved CMS procedures, more training, and improved sanctioning procedures for facilities. Any improvements in the enforcement process should address what states consider to be serious barriers to an effective enforcement system.

The following are several potential federal policy responses to the problem of widely varying state survey agency performance.

1. **Increase Federal Funding.** Increasing federal funding may be appropriate as one part of a larger policy response. Federal funding for survey and certification that is tied, as a fixed percentage, to estimated federal Medicare spending on nursing homes may be a rational method for removing the uncertainty and political considerations inherent in the Congressional appropriations process. A policy design feature to consider would be to require states to maintain their current level

of state effort in order to qualify for significant federal increases in funding.

2. **Improve the Enforcement Process.** The federal regulations and procedures for survey and enforcement should be reviewed for ways to improve the effectiveness of the process, especially the federal intermediate sanctions procedures. As long as states consider the federal system to be bureaucratic and cumbersome in implementing sanctions, they are unlikely to use the system to the extent intended to implement OBRA 1987. This is consistent with the recent IOM (2001) report that recommended improvements in the enforcement system for nursing homes to make sanctions more timely and effective.
3. **Increase Federal Oversight of State Survey Agencies.** The relationship between state survey agency resources and performance is just one factor. Increased funding alone will not solve agency performance problems. CMS has done a great deal in recent years to improve state performance --- such as develop new nursing home survey protocols, identify facilities that need more frequent inspections, implement an abuse intervention campaign and enhanced regional office oversight of state agencies. However, as contractors for the federal government, many states are still performing poorly.

Any increase in funding for survey and certification should include an amount set-aside for additional oversight of state survey agencies. In addition, CMS should be given the political ability to enforce its contract with state agencies by reducing Medicaid payments to states where agency performance is poor.

4. **Competitive Contracting.** Ultimately, CMS should be able, if needed, to contract with another organization or agency to undertake Medicare and Medicaid survey and certification activities where the state survey agency's performance is unacceptable, thereby risking the health and safety of Medicare and Medicaid beneficiaries.

In FY 2000, the federal government contracted with states for \$247 million to monitor nursing home quality and enforce federal regulations. The federal government has a duty to ensure its money is well spent. Doing this requires adequate federal funding, strict federal oversight of state performance and the ability to punish poorly performing states

and contract with outside organizations when necessary.

Data for this report was drawn from a survey of state licensing and certification agency directors or their designees during the year 2000 and from the 1999 HCFA On-Line Survey Certification and Reporting (OSCAR) system. The researchers also used OSCAR data from the American Health Care Associations 1999 annual nursing facilities sourcebook and OSCAR data compiled by CMS in its Report to Congress on Minimum Nurse Staffing Ratios in Nursing Homes. Other sources of state-level statistical information included the U.S. Bureau of the Census and the National Conference of State Legislators.

Appendix A

Table 1: Summary of backward OLS stepwise regression models for indicators of state agency performance indicators. Unstandardized coefficients (with standard errors in brackets).

	Mean # of deficiencies recorded per facility surveyed (1999)	# of facilities surveyed with no deficiencies (1999)	% of facilities surveyed with deficiencies G or above (1999)	% of surveys over 18 months since previous survey (1999)	Mean time (days) between surveys (1999)	Mean # of complaints investigated per bed (1999)	% of complaints investigated (1999)
Constant	1.05 (1.11)	47.60** (14.09)	6.78 (18.46)	7.293 (10.74)	213.96** (43.59)	6.837 (5.747)	156.37** (35.24)
Licensing and certification spending per bed (2000)	0.00413* (0.002)	0.0147 (0.012)	0.0287* (0.013)				
% licensing and certification spending from federal sources (2000)			0.113 (0.096)				
% facilities in chain ownership (1999)	0.0521** (0.018)	-0.305* (0.119)	0.278* (0.114)		-0.848 (0.481)		
% facilities in for-profit ownership (1999)		0.158 (0.106)		0.063 (0.050)		0.0414 (0.020)	-0.365* (0.142)
% residents funded by Medicaid (1999)		-0.254 (0.196)	-0.455* (0.209)				0.414 (0.324)
% facility beds not Medicare/Medicaid certified (1998)	0.110** (0.039)	-0.374 (0.219)			1.88 (0.999)		-0.790 (0.411)
Mean total staff hours per resident day (1999)						1.508 (0.996)	
Mean no of beds per facility (size) (1998)			0.201* (0.080)	0.132** (0.036)	1.06** (0.291)		-0.103 (0.101)
Mean % facility occupancy (2000)				-0.155 (0.112)		-0.139** (0.045)	-0.811* (0.395)
F statistic	8.06**	2.964*	2.601*	4.879**	8.153**	6.434**	2.494*
Adjusted R-squared	0.298	0.164	0.138	0.189	0.300	0.246	0.130

(* = p < 0.05; ** = p < 0.01)

Source: Analysis prepared by the Department of Social & Behavioral Sciences, University of California, San Francisco for the Kaiser Commission on Medicaid and the Uninsured.

ENDNOTES

¹ Walshe, K. and Harrington, C. 2002. The Regulation of Nursing Facilities in the US: An Analysis of the Resources and Performance of State Survey Agencies. *The Gerontologist*. In Press. For more information on the survey, contact C. Harrington at 3333 California St. Suite 455, San Francisco, CA 94118.

² Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group

³ The Social Security Act 1919.

⁴ Social Security Act, 1919 (b) (2) and (b) (3).

⁵ Kieran Walshe, Regulating U.S. Nursing Homes: Are We Learning From Experience? *Health Affairs*, Volume 20, Number 6.

⁶ The Social Security Act 1919(g)(3)(b) through 1919 (g)(3)(c).

⁷ U.S. General Accounting Office (GAO). 1998. California Nursing Homes: Care Problems Persist Despite Federal and State Oversight. Report to the Special Committee on Aging, U.S. Senate. GAO/HEHS-98-202. Washington, DC: U.S. GAO, July.

⁸ Ibid.

⁹ U.S. Department of Health and Human Services (USDHHS). 1998. HHS Fact Sheet: Assuring the Quality of Nursing Home Care. Washington, DC: HCFA Press Office, July 21.

¹⁰ FY 2002 President's Budget, p. 458 and unpublished data from CMS.

¹¹ Unpublished data from CMS.

¹² Conversation with CMS Staff.

¹³ Social Security Act, Title 19

¹⁴ Conversation with CMS.

¹⁵ The standard deviation of 55 days (equal to about 20 percent of the average) means that a state's average time between surveys for each facility could be reasonably expected to fall between 232 and 342 days. On average, states investigate about 79 percent of all complaints and a state's average could be reasonably expected to fall between 62 and 96 percent.

¹⁶ Because the standard deviation for this measure is so large (2.16 deficiencies per facility) relative to the average, a state's average number of deficiencies per facility could be reasonably expected to fall anywhere between 2.79 and 7.56.

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