

CHAPTER

4

Improving quality assurance for institutional providers

R E C O M M E N D A T I O N S

4A The Secretary should require providers participating in Medicare to report a minimum, core set of data needed to generate standardized, evidence-based measures of quality and other dimensions of facility performance.

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4B To strengthen the evidence basis of Medicare’s conditions of participation, the Secretary should support additional research on the relationship between health care outcomes and both structural characteristics and processes of care.

.....

4C The Congress should mandate the Secretary to review and update the conditions of participation on a specific periodic basis and should require the use of negotiated rulemaking to do so.

.....

4D The Congress should require that the Secretary annually survey at least one-third of each facility type to certify compliance with the conditions of participation. The Secretary should also monitor facilities’ compliance with conditions of participation on an ongoing basis.

.....

4E The Secretary should request, and the Congress should appropriate, adequate levels of funding for survey and certification activities to enable HCFA and state survey agencies to increase the frequency of inspections and take other steps to strengthen the quality oversight process.

.....

4F The Congress should assure that the federal appropriations process does not impede states’ abilities to fund Medicare and Medicaid survey and certification activities.

.....

4G State survey agencies should use health care quality measures and other measures of facility performance to:

- determine which facilities to survey more and less frequently,
 - target specific issues or quality concerns for focused attention in the survey process, and
 - monitor facility performance between inspections.
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4H The Congress should authorize the Secretary to develop intermediate sanctions specific to each institutional provider type that reflect the scope and severity of the deficiency and to consider a provider’s past performance in levying sanctions.

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4I The Secretary should take additional steps to ensure that private accrediting organizations with Medicare deeming authority are, in fact, ensuring that facilities meet Medicare certification standards.

.....

4J The Secretary should make more information about the results of the survey and certification process available to beneficiaries.

Improving quality assurance for institutional providers

Medicare's quality assurance system—essentially a regulatory process through which providers' capacities to safely furnish quality care are assessed against established standards—needs to be strengthened if it is to meet its intended objectives. MedPAC believes the system must be preserved, as it benefits not only program beneficiaries, but also all patients who use Medicare-certified providers. However, the Congress and the Secretary must address critical problems with the system by updating standards more frequently, funding the system adequately, strengthening sanctions, and making other changes. In addition, the Secretary must ensure that new tools for measuring the quality of care providers furnish are used appropriately and that quality improvement activities complement, rather than erode, Medicare's quality assurance system.

In this chapter

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 - The changing context for quality assurance
 - Addressing problems with Medicare's quality assurance system
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Quality assurance (QA) aims to provide a means of ensuring that health care providers have the capacity to furnish safe care of good quality. Medicare's QA system must serve this vital role in patient protection, but the present system is failing in important ways to meet the needs of most stakeholders.¹ To continue to assure that Medicare beneficiaries obtain quality health care, policymakers must take steps to address those failings and to ensure that Medicare's QA system evolves with changes in the program and the larger health system.

Medicare's quality assurance system for institutional providers is essentially a regulatory process that involves establishing conditions of participation (COPs)—known as conditions of coverage for some types of providers—through a rulemaking process and assessing provider compliance with those conditions.² Conditions of participation consist primarily of structural requirements believed to ensure the capacity of providers to safely furnish quality health care. Compliance is assessed either through a survey and certification process conducted by state agencies under contract to the Health Care Financing Administration (HCFA), or through a private accreditation process that HCFA has determined to be equivalent to its own.³

As it stands today, Medicare's QA system is satisfying none of its stakeholders. Health care providers complain that the system is expensive, burdensome, and seemingly focused on aspects of the organization and delivery of health care that are not important determinants of quality. Consumer advocates decry the lack of information publicly available on outcomes of the QA process and the lack of consumer representation. Policymakers

are dubious that the system achieves its intended effects.

However, the need for a strong system of quality assurance is evidenced by recent examples of substandard quality reported in the news media, as well as by reports from federal oversight agencies. For example, a 1999 report by the U.S. General Accounting Office (GAO) revealed that more than one-fourth of the nation's nursing homes had caused actual harm to residents or placed them at risk of death or serious injury at some point during the previous year (GAO 1999). The President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, the Institute of Medicine's National Roundtable on Health Care Quality, and other experts have concluded that quality problems such as underuse, overuse, and misuse of services can be measured and that these problems have been documented as serious and extensive (Quality Commission 1998, Chassin et al. 1998).

This chapter presents the findings from an examination by the Medicare Payment Advisory Commission (MedPAC) of Medicare's system for establishing and enforcing minimum health care quality and safety standards for institutional providers.⁴ It begins by describing the evolving roles in quality assurance played by key participants and assesses whether and how those roles might be strengthened. It next considers two key changes in the context for quality assurance—the rise of the quality improvement movement and the development of health care quality indicators that can be used to evaluate provider performance—and assesses the implications of these developments for Medicare. The chapter's final section

focuses on specific problems with Medicare's QA system and considers ways in which it might be improved.

Roles in Medicare quality assurance

Policymakers addressing problems with Medicare's QA system must consider the roles played by key participants—public sector entities, private accrediting bodies, and beneficiaries. Policymakers may disagree on which participants are best suited for which roles. Some might argue that the Medicare and Medicaid programs, which serve primarily as health care purchasers, do not provide the most appropriate vehicles for identifying quality and safety standards and ensuring that those standards are met. Alternative approaches might draw upon the resources of other public- or private-sector entities for setting standards or for determining or enforcing compliance. At the same time, the role of beneficiaries in Medicare QA could be strengthened to help ensure that the system better meets their needs.

Current roles

The public sector currently takes the lead in assuring quality in the Medicare system. HCFA, as the administrator of the Medicare and Medicaid programs, is responsible for establishing quality standards for numerous types of providers and suppliers that furnish care to beneficiaries and for enforcing compliance with those standards. In accordance with statute, the agency has established such standards for hospitals; long-term care (LTC) facilities⁵; home health agencies; comprehensive outpatient rehabilitation facilities; hospices;

1 Medicare and Medicaid use the same conditions of participation and certification process. For convenience, this chapter refers to Medicare's quality assurance program.

2 Program regulations distinguish health care providers and health care suppliers. The former are generally subject to conditions of participation (sometimes called requirements) and the latter to conditions of coverage. In this chapter, the term "provider" is used to refer to both providers (such as hospitals) and suppliers (such as renal dialysis facilities).

3 Because the hospital accreditation program of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is specified in law as satisfying Medicare and Medicaid participation standards, JCAHO's status is not dependent upon HCFA's assessment of its accreditation standards and compliance assessment methods.

4 HCFA has a comparable program in place for health plans participating in Medicare+Choice.

5 The term "long-term care facility" refers to skilled nursing facilities (subject to Medicare program certification) as well as to nursing facilities and intermediate care facilities for persons with mental retardation (subject to Medicaid program certification).

rehabilitation agencies, clinics, and public health agencies operating as providers of outpatient physical therapy or speech pathology services; independent laboratories; renal dialysis facilities; rural health clinics; portable X-ray services suppliers; ambulatory surgical centers; critical access hospitals; organ procurement organizations; and religious nonmedical health care institutions. Other agencies within the federal Department of Health and Human Services also play roles in promoting the quality of the nation's health services. For example, the Food and Drug Administration (FDA) establishes and enforces compliance with quality standards for mammography facilities and, with HCFA, administers oversight of clinical laboratories.

States also play a role in Medicare's QA process. Under contract to HCFA, state survey agencies conduct Medicare and Medicaid certification surveys to assess compliance with program standards. Because these agencies can conduct Medicare and Medicaid certification inspections in conjunction with those required by state licensure requirements, this contractual relationship serves to minimize duplicative oversight.

Private accreditation entities also contribute to Medicare's QA system by conducting compliance assessments for certain types of providers in lieu of the state survey agencies. Providers accredited by federally approved bodies are considered to have met Medicare participation requirements.⁶ Under the initial Medicare legislation, the Congress granted the Joint Commission on Accreditation of Healthcare Organizations (JCAHO, then called the Joint Commission on Accreditation of Hospitals or JCAH) "deeming authority" for Medicare certification, meaning that hospitals accredited by JCAHO were

certified to participate in Medicare.⁷ In 1984, the Congress expanded HCFA's authority to rely on private accreditation groups to review compliance with Medicare quality standards for providers other than hospitals as part of their accreditation activities. HCFA is now required to grant this "deeming" authority to any national organization that accredits certain types of Medicare providers, if that entity can show that its accreditation requirements meet or exceed those contained in title XVIII.⁸ The agency is allowed, but not required, to grant deemed status to accrediting entities for LTC facilities. It is not authorized to grant deemed status to organizations that accredit renal dialysis facilities or durable medical equipment suppliers.

The role of the state survey agencies and designated private accreditation bodies is comparable, but not identical. State agencies have the authority to require corrections of identified problems and can recommend sanctions for providers that fail to correct problems. Because private accreditation is voluntary, accrediting bodies cannot sanction providers. They can recommend corrections and revoke accreditation or otherwise change accreditation status if providers fail to implement recommended changes. A provider that loses its accredited status is also referred to HCFA for a survey to evaluate compliance with program requirements.

Beneficiaries are also involved in the QA process, although at present they are more affected parties than active participants. Because their interests in QA are diffuse, it is unlikely that their views are adequately represented in the development of Medicare's QA standards. In addition, they have a limited role in compliance determination and the oversight process. State survey agencies

consider beneficiary complaints to some extent when making program recertification decisions. Only long-term care facilities and home health agencies have beneficiary interviews built into the survey process. Finally, little information about the QA process and its results is currently available to beneficiaries. Again, long-term care serves as an exception, in that HCFA makes available on its Web site some comparative information about deficiencies cited in such facilities (HCFA 2000).

Considerations in changing roles

One of the issues MedPAC addressed was whether changes in current roles would benefit the program. The Commission specifically considered which participants ought to be responsible for setting, and for assessing and enforcing compliance with, QA standards, and whether and how the role of the beneficiary could be strengthened.

Public-sector responsibility to set and enforce minimal standards

MedPAC believes that developing and enforcing compliance with minimum quality standards is a responsibility that should continue to be borne by a public-sector entity. The views of multiple stakeholders need to be taken into account in developing such standards and a strong patient or consumer focus is particularly needed. Public-sector bodies can ensure opportunities for participating in standard-setting efforts and can provide other public safeguards. Moreover, government traditionally sets regulatory quality and safety standards in many industries, including transportation, drugs, and food. Compared with the private sector, the public sector offers more effective channels for enforcing compliance with minimum standards.

6 Similarly, many states allow hospitals or other providers to demonstrate compliance with licensure requirements by attaining accreditation from an approved private oversight body.

7 Some say that JCAH was written into the original Medicare legislation in an effort to encourage the participation of hospitals and physicians, who were comfortable with the JCAH accreditation program. Reliance on private accreditation was also a way to keep the program from being seen as inappropriately intruding into the practice of medicine or hospital management. Finally, the Congress indicated in the legislative history to the original Medicare legislation that it did not want to supplant the hospital industry's quality assurance activities, but to support private efforts to improve quality of care in hospitals (Kinney 1994).

8 This change was effectuated under sections 2345 and 2346 of the Deficit Reduction Act of 1984 (P.L. 98-369) and section 6019 of the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239), which amended section 1865(a) of the Social Security Act.

HCFA is not the only potential public-sector source for setting and enforcing national patient health and safety standards, however. Other possible public-sector approaches would entail developing new venues for oversight—through one or more Public Health Service agencies, such as the FDA, for example. This approach would reduce the responsibilities borne by HCFA, potentially freeing resources to meet direct program administration functions. This approach also would better reflect the nature of any benefits from QA, which accrue to all patients and are not targeted exclusively to Medicare and Medicaid beneficiaries. However, this approach could entail considerable expense and might not result in notable differences from the existing system in terms of effectiveness or other outcomes.

Heavier reliance on states to oversee health care quality is another option MedPAC considered. This approach would strengthen states' traditional role of protecting public health and safety. Some states have undertaken innovative approaches to set and enforce health quality standards that exceed federal requirements (OIG 2000b). For example, New York uses hospital mortality data to assess hospital performance, and Utah Health Department officials participate in the on-site surveys of hospitals conducted by JCAHO. If policymakers decided to rely more on states for undertaking QA responsibilities, however, state licensing would arguably need to be strengthened (at the very least, in funding).

Several factors detract from the appeal of strengthening state oversight responsibilities. At present, licensure requirements vary by state in terms of which providers are required to be licensed, how stringent standards are, and how compliance is determined and enforced. Federal standards, as currently

provided by the Medicare certification program, ensure that nearly all health care providers (those that participate in Medicare or Medicaid) meet a common set of core requirements. Further, some types of providers—renal dialysis facilities, for example—do not widely use private-sector accreditation services at present and are not licensed by all states.⁹ For some of these providers, Medicare's certification process serves as the only existing form of external oversight, thereby offering potential benefit not only to program beneficiaries, but also to all patients using Medicare-certified providers.

MedPAC believes that Medicare and Medicaid, as large national health insurance programs, together provide an appropriate vehicle for accomplishing the public-sector responsibility of establishing and enforcing minimal standards, absent another federal body charged with doing so. The programs should continue to use their authority as purchasers to ensure that the health care they buy meets appropriate minimum safety and quality standards. In implementing and enforcing quality standards, regulators must coordinate their standards and oversight procedures to ensure that federal and state QA programs do not conflict.¹⁰

Private-sector role in assessing compliance and promoting excellence

The Commission also continues to see a strong role for accrediting organizations in QA. MedPAC believes it is desirable and appropriate for private entities to establish voluntary quality standards that surpass Medicare's in stringency. Such accreditation programs offer providers a means to distinguish themselves among their competitors. MedPAC also supports continued reliance on accrediting organizations to assess compliance with

Medicare's quality standards. This reliance greatly reduces the burdens on state agencies and health care providers. However, it is important that accreditation continue to provide a QA function by identifying providers whose performance is substandard so that action may be taken to protect beneficiaries while problems are remedied.

MedPAC considered whether the role of the private sector in setting minimal standards should be strengthened. This could be accomplished by requiring participating providers to attain accreditation. Moving more QA responsibilities to these groups could address concerns that government entities are not "light enough on their feet" to accommodate the changing needs of the rapidly evolving health care industry and that government rulemaking processes are likely to yield standards that are beneath the state of the art or less stringent than those demanded by other health care purchasers (health plans and employers). However, strengthening the role of the private sector in this way could decrease public input and oversight, which could result in ineffective standard-setting or policing of compliance. In addition, national accrediting organizations may have more difficulty becoming familiar with the particular characteristics of local health care delivery than state-based survey agencies have.

Strengthening the role of the beneficiary

MedPAC also considered whether Medicare beneficiaries could and should play a larger role in helping to determine whether providers are meeting minimal standards. This could be accomplished by surveying beneficiaries about the delivery of health care services by specific providers.¹¹ Medicare's quality assurance process does not formally collect

⁹ At present, renal dialysis facilities have little incentive to seek private accreditation because HCFA lacks the authority to deem accredited centers as compliant with Medicare standards. Because Medicare is the predominant payer for renal dialysis services, health plans or other purchasers can exercise little market power to favor accredited centers.

¹⁰ The National Quality Forum, a private-sector body formed on the basis of recommendations by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, may provide a vehicle for coordinating standards and quality measures across purchasers, regulators, and other interested parties. Both HCFA and the Agency for Healthcare Research and Quality play roles in the National Quality Forum.

¹¹ Some have also suggested increasing the formal use of information derived from beneficiaries' complaints in the survey process. This might be accomplished by undertaking analysis of complaints data to identify patterns in the nature and extent of problems reported by beneficiaries.

beneficiary evaluations in determining providers' compliance with the COPs, primarily because of the program's reliance on structural measures, which have few components and attributes that might be evaluated by beneficiaries.¹² As HCFA modifies the COPs to include process of care measures, the merits of collecting and using beneficiaries' evaluations in the oversight process need to be carefully considered. To this end, HCFA and the Agency for Healthcare Research and Quality are examining the feasibility of designing a survey instrument—similar to that used in the Consumer Assessment of Health Plans Survey—for residents of skilled nursing facilities. Such a survey would provide state survey inspectors with information about the delivery of health care services.

The Commission encourages the Secretary to continue studying the feasibility of using beneficiaries' formal evaluations of compliance determination in the oversight process. HCFA must address the reliability and validity of beneficiary evaluations of the technical components and attributes of care. Researchers are still evaluating the extent to which patients can evaluate the technical aspects of health care delivery. The agency will also need to address other issues, including biases that might affect beneficiary evaluations (such as how different levels of cognitive impairment affect responses), the use of proxies, the design of survey instruments, and sampling procedures.

The changing context for quality assurance

Two important changes have occurred in the Medicare program and the larger health system context that potentially affect Medicare's QA system.

TABLE 4-1

Characteristics of quality assurance and quality improvement models of external oversight, as applied in health care

Characteristic	Quality assurance	Quality improvement
Objective	To identify problems	To improve average performance
Focus	Individual accountability	System redesign
Approach	Regulatory	Collegial, cooperative
Scope	Comprehensive	Specific quality issues
Means	Requirements	Improvement goals
	Compliance assessments	Outcome and process measurement
	Corrective action plans	Education and outreach
	Sanctions	Technical assistance

One change is the rise of quality improvement (QI) as an approach for addressing quality of care. This approach—also known as continuous quality improvement or total quality management—has been adopted for use in many industries and has recently begun to influence health care industry practices (Shortell et al. 1998). Medicare policymakers face questions about the appropriate role for QI in the program and how best to address the tension between the QA and QI approaches.

A second critical development is the increasing availability of facility-specific measures of health care quality and other aspects of performance. Medicare's ongoing implementation of facility performance measurement systems provides opportunities for making important changes in the COPs and the means for determining compliance with them.

Rise of quality improvement

Quality assurance and quality improvement represent two approaches for influencing the quality of care (Table 4-1). Quality improvement reflects the

notion that improving the average quality of care furnished by providers is an important goal that can be attained only in a blame-free environment in which providers are encouraged and assisted to assess their performances, make changes, reassess quality, and strive for continuous improvements. In this model, the regulatory mindset of rooting out poor performers and holding them accountable through a punitive process is considered ineffective and counterproductive. As the QI approach increases in prevalence and influence, Medicare policymakers must determine the appropriate role for QI in Medicare and the relationship between QA and QI.

Appropriate emphasis on quality improvement

One important policy question is the extent to which Medicare should emphasize QA (setting minimum standards and enforcing compliance) as opposed to QI (facilitating and requiring improvement). MedPAC believes that a QA system is essential and must be strengthened, but that the appropriate level of emphasis on QA versus QI could vary.

12 Some information about patient perceptions is currently obtained during inspections of long-term care facilities and home health agencies. This information is gathered informally, however, without the use of survey forms or formal procedures. For example, as a part of the inspection process for nursing facilities, surveyors are required to tour a facility for about three hours and to converse with residents, family members/significant others, and facility staff to develop an overall picture of the types and patterns of care delivered within the facility (42 CFR §488.110). Surveyors are required to meet with resident council representatives and randomly selected residents to gather information from the consumer perspective about the delivery of services in the facility, including strengths and shortcomings. In the standard survey of home health agencies, Medicare requires surveyors to visit the homes of a case-mix stratified sample of patients who received services from the agency, but does not require surveyors to conduct home visits of patients served by agencies' branch offices (GAO 1997).

Medicare's survey and certification process continues to have a strong QA orientation, both in the nature of the requirements and in the oversight process undertaken by state survey agencies. Some stakeholders have called for HCFA to adopt a more collegial, improvement-oriented approach in its regulatory oversight of providers, as certain private accrediting bodies have done (AHCA 1998). However, the Office of Inspector General (OIG) of the Department of Health and Human Services has criticized this approach as one that potentially undermines the existing system of patient protections afforded by certification practices (OIG 1999a).

Although the survey and certification process remains firmly rooted in the QA approach, Medicare has begun to employ the QI approach in other facets of program operations. Most notably, it has changed the function of the peer review organizations (PROs), which now refer to themselves as quality improvement organizations, although they are still known as PROs in statute and regulation.¹³ The PROs originally focused on reviewing individual cases, based on a sample of hospital discharges, to uncover instances of substandard care.¹⁴ However, the functions of these organizations have changed with each successive three-year contract and they now do very little case review. Instead, they focus on developing and conducting voluntary "quality improvement projects," in which quality is measured, interventions (such as provider education or beneficiary outreach) are conducted, and quality is reassessed. The QI projects focus primarily on inpatient hospital care, although PROs are required under their current contract to conduct one QI project on care provided in another setting. Although physicians and other providers are not required to participate in these

projects and are not held accountable for achieving improvements, Medicare has begun to hold the PROs contractually responsible for improving average statewide performance on specific quality measures.

Some might question whether the expansion of QI programs in Medicare obviates the need for QA, but MedPAC believes that the two approaches can complement one another and that QA continues to be essential. Quality improvement activities usually focus on a particular quality concern, such as care for patients admitted with acute myocardial infarction, as opposed to the comprehensive focus of QA. In addition, at least when employed as an external oversight mechanism, QI generally relies on pooled data to evaluate average performance, whereas QA focuses on an individual provider's performance. Without some effort to review providers' capacities and achievements comprehensively, there is a danger that QI activities could proceed successfully while certain providers failed to take basic safety precautions, thus putting patients at risk.

Despite a continued need for QA, the same balance of QA and QI may not be appropriate for all providers. MedPAC believes Medicare policy should emphasize QA for certain institutional providers, such as:

- those with poor track records in ensuring quality of care,
- those that furnish care that is particularly subject to safety risks,
- those that serve disproportionately vulnerable populations, and

- those that lack the capacity to undertake sophisticated internal quality assessment, assurance, and improvement activities.

For example, focus on QA in the LTC arena could be justified by the vulnerability of the patients these facilities serve. These patients are disproportionately cognitively impaired, lacking in social or familial supports, and otherwise less likely to recognize or report substandard care. Quality assurance could be emphasized by strengthening standards, increasing efforts to evaluate compliance, and taking stronger actions against poor performers.

For other providers, increased emphasis on setting and addressing QI goals might be appropriate. Emphasis on QA for these providers might be decreased by reducing the frequency or scope of site inspections and relying on performance data submission to monitor compliance, while strengthening requirements relating to internal QI programs or participation in QI activities sponsored by outside organizations.

Medicare's standards for participating health plans, newly revised with the creation of the Medicare+Choice program, provide an example of how QA and QI requirements might be combined. Medicare continues to set, monitor, and enforce minimum structural requirements for plans, as it has traditionally. However, HCFA now also requires coordinated care plans participating in the Medicare+Choice program to measure and report on processes and outcomes of care, using measures from the Health Plan Employer Data and Information Set (HEDIS).¹⁵ These measures, many of which evaluate the extent to which appropriate care is underused, are to be incorporated into the review process, and

13 The end-stage renal disease network organizations perform a parallel function for renal dialysis facilities.

14 According to HCFA officials, the case-review approach was de-emphasized because research showed the approach to have only modest reliability, PRO action based on such reviews tended to lead to acrimonious disagreements, and review of quality on a case basis did not lend itself to quantitative measurement of quality (Jencks and Wilensky 1992).

15 Under the Balanced Budget Refinement Act of 1999, the Congress exempted preferred provider organizations from these quality requirements and mandated MedPAC to study the appropriateness of various quality standards for different types of health plans and providers participating in Medicare.

HCFA plans to define minimum standards for performance on HEDIS measures. Plans will be required to meet these standards to remain in compliance. In addition, new requirements call for coordinated care plans to maintain their own internal quality improvement programs and to achieve demonstrable improvements in health care outcomes using those programs. Health plans may draw upon the resources of Medicare's PROs to assist in meeting these requirements, although they are not required to do so.

Separation of quality assurance and quality improvement functions

A second important policy question is whether it is both desirable and possible to separate QA and QI functions. Many experts believe that quality assurance and quality improvement must be separate activities, because those responsible for policing quality of care and provider adherence to standards cannot provide the blame-free environment necessary for quality improvement. They note that providers will be reluctant to share information if they believe it may be used against them punitively. However, interaction between QA and QI may be inevitable in a system with goals to accomplish both. In addition, some collaboration, through data sharing or other means, may be desired to improve the effectiveness of each.

MedPAC believes it is important for Medicare to strengthen quality assurance and promote quality improvement simultaneously. The challenge will be to create an environment in which useful cross-fertilization can take place without compromising either objective. To the extent possible, separate entities should be responsible for QA and QI functions. Data sharing and other types of collaboration should be encouraged and facilitated, although sharing information that allows for identification of individual patients or practitioners should be prohibited.

Medicare's QA and QI systems increasingly overlap. For example, the PROs, which now operate primarily as vehicles for promoting and facilitating QI, retain a limited vestige of quality assurance responsibilities, in that they are responsible for investigating beneficiary complaints regarding specific instances of potentially substandard quality of care and for conducting case review in a few other limited instances. In addition, PROs were recently assigned the controversial responsibility of managing a new payment error prevention program, designed to uncover billing mistakes. Some are concerned that this program could reactivate the former adversarial relationship between providers and PROs, and that it might detract the organizations from their priority focus on quality of care.

As policymakers consider expanding the role of the PROs with respect to the sensitive area of errors in health care delivery, it is particularly important that the organizations retain the provider trust they have worked to achieve.¹⁶ In the past, PROs have not focused on health care error reduction, but their experience and the confidentiality protections afforded by the Peer Review Act make them a possible candidate for work in this area. They could serve as a repository for information on errors, a mechanism for analysis and feedback of information about root causes of errors, and a resource for improving systems to avert future errors.¹⁷

Another example of mixing QA and QI is the quality medical review pilot project for skilled nursing facility (SNF) care, in which five state survey agencies are working in conjunction with PROs and fiscal intermediaries (FIs) to identify facilities that require enhanced oversight or QI interventions. One of the questions to be addressed through the project is whether program integrity, quality of care, and medical review contractor roles can

be improved by coordinating their activities. In this particular case, the risk appears to be that the policing functions of the FIs and the state agencies are compromised by their roles in QI activities, rather than that the PROs lose providers' trust by cooperating with entities that have regulatory functions. This is because PROs' QI role continues to be largely confined to inpatient hospital care and the PROs have not established themselves as a QI resource for SNF care.

At present, most data sharing across state survey agencies, accreditation bodies, PROs, end-stage renal disease (ESRD) network organizations, and other organizations that play roles in Medicare QA or QI appears to occur primarily on an ad hoc basis. For example, in her testimony before MedPAC in October 1999, Kathleen Smail, Oregon's manager of health care licensure and certification, stated that her agency had developed a strong cooperative relationship with the state PRO, but had been unable to develop the same relationship with the ESRD network organization (Smail 1999). Speaking on behalf of JCAHO, Margaret VanAmringe noted that informal data sharing occurs, but that better data systems need to be created to systematically share complaint data, survey findings, and other information of interest to multiple parties (VanAmringe 1999).

Development of performance measures

Medicare's QA system has focused on assessing providers' capacities to provide safe care of good quality, because judging the actual quality of health care furnished by particular providers was infeasible until recently. However, new tools for measuring quality and performance are increasingly available and are beginning to be harnessed in performance measurement systems to generate information on a routine basis.

¹⁶ According to a February 22 release by the White House, HCFA will develop a pilot project within 6 months to establish medical error reporting systems in up to 100 hospitals. The pilot system will be mandatory, confidential, and penalty free. The PROs will maintain and analyze the data generated through the system.

¹⁷ MedPAC considered this option in its chapter on Medicare's role in addressing health care errors and patient safety in its June 1999 Report to the Congress.

These performance measurement systems represent significant opportunities for Medicare QA. Medicare could incorporate such measures into the COPs by requiring providers to report standardized indicators, attain specified performance levels, or improve specified aspects of performance. The program could also use such measures as part of its oversight efforts by considering provider performance on standardized measures when determining the appropriate frequency of site inspections, using relative performance levels to target specific issues or quality concerns in the course of a particular inspection, or monitoring facilities between inspections.

RECOMMENDATION 4A

The Secretary should require providers participating in Medicare to report a minimum, core set of data needed to generate standardized, evidence-based measures of quality and other dimensions of facility performance.

Incorporating facility performance measures in Medicare QA remains highly challenging. It requires two important conditions.

First, Medicare must identify appropriate measures of health care quality and other relevant aspects of provider performance. Such measures must be able to generate meaningful information that is reliable at the individual facility level. Of interest are process measures (such as measures of underuse, overuse, or misuse of services) that are strong determinants of outcomes, and outcome measures known to be strongly influenced by factors within the control of the provider. Outcome measures likely to be influenced by factors associated with patient mix must include risk adjusters or should be used in QI programs, rather than in QA programs designed to attain accountability for performance. To ensure efficient use of resources and minimize the burden on providers associated with meeting unnecessarily divergent requirements,

HCFA should work with other public and private-sector groups with interests in this area to identify appropriate quality measures. The National Quality Forum may provide a vehicle for identifying core quality measures and coordinating the public reporting of information on quality.

Second, Medicare must obtain current, reliable data by which to measure quality. Such data must be consistently reported by all facilities using common definitions and metrics. An important issue to consider is whether the performance measures should be based on data that would not otherwise be collected for payment or other purposes. Using a measure that requires new data to be collected may potentially be burdensome for providers. At the same time, few measures of health care quality can be generated from many data collected for payment purposes. Information from patient medical records, patient assessments, or survey data often must be used instead.

Medicare is now implementing setting-specific systems for measuring health care quality and other aspects of facility performance. For a few provider types (such as LTC facilities and home health agencies), systems to measure health care outcomes and processes of care at the facility level are now operational. For a few other types of providers (such as renal dialysis facilities), such performance measurement systems are now in development. For most other providers (notably hospitals), Medicare has not yet established standardized systems for quality measurement and reporting.

As HCFA moves to implement facility performance measurement systems, it must work to obtain buy-in from health care providers and to minimize the data reporting burden associated with these new systems. Provider organizations' reactions to Medicare's performance measures initiatives have been mixed. In general, providers seem to support the notion of accountability for performance compared with the alternative: structural

requirements, which are seen as more prescriptive and constraining. However, providers also object to the burden associated with collecting and reporting data not required either for payment or for care planning or management. To ease this burden, HCFA has made available in the public domain software designed to assist in standardized data collection and reporting for the Minimum Data Set, used in determining payments and measuring quality of nursing facility care, and the Outcome and Assessment Information Set, used in determining payments and measuring quality of home health care. In its March report to the Congress, MedPAC recommended that HCFA take other steps to make the collection of data needed for quality measurement more rational (MedPAC 2000).

Addressing problems with Medicare's quality assurance system

A strong system of quality assurance is essential, but problems with Medicare's QA system diminish the likelihood that it achieves its intended effects. In this section, we review problems with:

- the participation standards,
- the process for certifying compliance with those standards,
- the ability to enforce compliance,
- Medicare's deeming arrangements, and
- the limited information available to consumers on certification findings.

Recommendations are provided to address many of the identified problems.

Problems with the standards

Medicare's participation requirements are actually broad quality precepts, composed of factors that demonstrate an entity's compliance with the condition.

Conditions of participation are developed by HCFA, with comments from interested parties.¹⁸ HCFA determines when COPs require revisions by maintaining ongoing contact with outside groups and monitoring a range of indicators. The update process can be triggered by specific survey results, changes in payment systems, patient deaths or other serious quality events, congressional mandate, or the identification of loopholes or other problems with the current COPs.

Regulations containing the COPs are drafted through a collaborative process among relevant HCFA divisions and departmental contacts. Agency staff, in turn, maintain contacts with outside interested parties to gain their input. Town hall meetings have also been used to facilitate the standards development process and to keep HCFA up to date on the current direction of the industry. Due to legal constraints, HCFA cannot carry on informal discussions with interested parties about the specifics of regulations during the notice and comment process.

Limited evidence basis of standards

With the exception of the COPs for LTC facilities, program participation requirements tend to focus on structural and process factors thought to be required to deliver quality care.¹⁹ These standards were largely established through professional consensus. HCFA has said there is little evidence to demonstrate a connection between these structural and process requirements and positive patient outcomes (HCFA 1997a).

RECOMMENDATION 4 B

To strengthen the evidence basis of Medicare's conditions of participation, the Secretary should support additional research on the relationship between health care outcomes and both structural characteristics and processes of care.

The need to substantiate the connection between quality standards, such as the COPs, and quality of care has been highlighted in research (Brook et al. 1996). Moreover, standards that cannot be shown to improve quality may do no more than add an additional burden to already overburdened providers. Employing evidence-based standards in Medicare would be consistent with the current movement in health care that promotes the practice of evidence-based medicine.

Some research is being done in this area, but more is needed. HCFA has sponsored an assessment of staffing ratio requirements in nursing homes to determine whether such mandates are effective. This study will focus on whether increased staffing ratios improve care, whether minimum nurse staffing ratio requirements are appropriate, and the potential cost and budgetary implications of minimum ratio requirements (Fredeking 1999). A report on the first phase of this study is expected to be issued this summer.

Research alone will not improve the Medicare QA system; the process for updating the program's quality standards must also be improved. Without such a change, Medicare beneficiaries will not realize the full benefit of investment in research to strengthen the standards' evidence basis.

Lack of information on quality and performance

Although most participation requirements relate to structural characteristics of health care organization and delivery, HCFA is updating the COPs for many types of providers to replace such requirements with ones more focused on patient care outcomes. Doing so has a number of advantages; a major one is that desired outcomes are less subject to change over time, whereas processes and structures tend to change as medical practice and technology change.

To assist in setting patient care outcome standards, HCFA intends to move toward performance data collection requirements for some types of participating providers. It has already instituted new performance data reporting requirements in the COPs for home health agencies and LTC facilities. In the proposed revisions to the COPs for hospitals, HCFA invited comments on the possibility of developing similar performance data collection and reporting requirements.

Minimum performance levels

Because of challenges associated with defining minimum acceptable performance levels, MedPAC urges the Secretary to be cautious in defining such levels in Medicare's COPs. Even without setting minimum performance standards, the measures could be used to create accountability for performance, either by making the information publicly available or by using it to inform the survey process.

The Commission believes that in many instances, it will be prudent to require standardized measurement and reporting of certain aspects of performance without establishing specific performance

18 For example, in developing HCFA's proposed hospital COPs, the agency solicited comments from organizations representing hospitals, practitioners, patients, and states (HCFA 1997a). HCFA also distributed a preliminary draft of the proposal to 70 interested groups and used their comments to develop the proposed rule. In revising the home health agency COPs, HCFA collected comments through national meetings of providers, practitioners, beneficiary representatives, and state survey agencies (HCFA 1997b).

19 Pursuant to a contract with the Commission, Abt Associates Inc. reviewed the Medicare COPs for hospitals, long-term care facilities, home health agencies, rural health clinics, ambulatory surgical centers, and renal dialysis facilities. Abt assigned each of these facility COPs to one of 16 identified categories, which included utilization/quality review and assurance, patient/resident rights, medical records/release of patient information, patient/resident plan of care, clinical measures of quality, and patient/resident assessment.

requirements in COPs. Taking the latter step requires determining what constitutes “acceptable performance,” not an easy task for many measures. Performance on many measures can fall along a wide spectrum; although for most measures, more or higher can be judged as better than less or lower, it is difficult to identify a particular cut-off point below which performance can be judged unacceptable. Setting minimum performance levels also requires identifying levels equally applicable to all providers of a particular type, including, for example, hospitals that are large, small, rural, urban, teaching, and nonteaching.

At present, Medicare has established particular outcome standards only for LTC facilities. Specified outcome measures include activities of daily living, pressure sores, incontinence, nutritional status, and medication errors. The standards specify that facilities are responsible for ensuring that residents do not develop new conditions or experience worsening of existing conditions, unless the patient’s clinical condition makes such changes unavoidable.

In pending revisions to the COPs, HCFA also proposed moving toward outcomes standards for hospitals, including requiring an overall medication error rate of no greater than 2 percent overall and 0 percent for “significant” medication errors. Given the early state of developing and instituting systems and processes for reducing errors, MedPAC opposes these proposed standards and comparable ones now in effect for LTC facilities (MedPAC 1999). However, the Commission recognizes the significance of and need for further development of measures and methods addressing health care outcomes.

Requiring performance improvement

Because of these challenges in defining minimum performance levels, requiring improvement in performance may be a more appropriate way to incorporate performance requirements into Medicare participation requirements. However, this

approach also presents challenges. Rather than considering comparative performance, it requires providers to improve their own baseline levels of performance. Its use in Medicare raises questions about creating a fair playing field, given that providers with performances vastly exceeding those of their peers may find it more resource-intensive to improve performance, compared with those who begin at a lower baseline. It also raises questions about whether it is desirable or appropriate for HCFA to move beyond defining minimal standards for safety and quality in the QA program.

In proposed COPs for several types of providers, HCFA is attempting to update standards that require providers to have their own internal systems to address quality of care. The COPs for most institutional providers currently include requirements that each maintain an internal QA program to identify quality problems and to develop and carry out

plans for remedying them. In proposed rules revising COPs for hospitals and home health agencies, HCFA would require providers to operate QI programs in which they must measure quality, take steps to improve it, and demonstrate improvements.²⁰

Infrequent updating of standards

The COPs for most facility types date back to the 1980s, and a few date to the 1970s and earlier. Table 4-2 lists the facility types and the dates of the most recent comprehensive regulatory revisions to the relevant COPs. The mere fact that such long periods have elapsed since the development of COPs leads some to argue that the standards are out of date and do not reflect current health care practices (McGeary 1990).

Revisions to the COPs for some types of facilities are in various stages of the regulatory process, but have yet to be

TABLE 4-2

Date of last comprehensive revision to facility conditions of participation

Facility type	Date
Hospitals	Jun. 1986
Long-term care facilities	Feb. 1989
Home health agencies	Aug. 1989
Comprehensive outpatient rehabilitation facilities	Dec. 1982
Hospices	Dec. 1983
Rehabilitation agencies, clinics, and public health agencies operating as providers of outpatient physical therapy or speech pathology services	May 1976
Renal dialysis facilities	Jun. 1976
Rural health clinics	Mar. 1978
Portable X-ray services suppliers	Jan. 1969
Ambulatory surgical centers	Aug. 1982

Note: Additional significant but less-than-comprehensive revisions were issued after these dates to several of the facility conditions of participation listed.

Source: MedPAC review of the Code of Federal Regulations and the Federal Register.

²⁰ Current standards for coordinated care plans participating in Medicare include this requirement.

made final. For example, comprehensive revisions to the home health COPs were proposed in March 1997 but have not yet been issued as a final rule (HCFA 1997b, HCFA 1997c).²¹ Proposed hospital COPs are pending, having been issued in December 1997. Revisions to the COPs for renal dialysis facilities, hospices, ambulatory surgical centers, and rural health clinics are in the planning stages, but have not yet been formally issued as proposed rules (DHHS 1999).

RECOMMENDATION 4C

The Congress should mandate the Secretary to review and update the conditions of participation on a specific periodic basis and should require the use of negotiated rulemaking to do so.

Two factors may explain the extensive time needed to revise the various COPs: the regulatory process is complicated, and HCFA has limited resources to carry out its mission.

Complications arise from a variety of sources. In promulgating regulations, HCFA must abide by the Administrative Procedures Act, which applies to all regulatory agencies and mandates that they follow certain processes in making rules or adjudicating disputes. Rulemaking must be done through a public process consisting of publishing a proposed rule in the Federal Register, providing an opportunity for public comment or participation, and publishing the final rule. Controversy surrounds the requirements facilities must meet to participate in Medicare, and proposed changes to those requirements raise many political issues. The regulatory process is

further constrained by executive orders and other statutory mandates that require certain additional agency actions when promulgating regulations.²² These laws and executive orders aim to protect the public interest but often slow the regulatory process.

The evolution of the hospital COPs exemplifies the complexities that arise in revising quality regulations. The initial COPs were sent to hospitals in January 1966, six months after enactment of the Medicare law, and published as final rules later that year. HCFA made several unsuccessful attempts to revise the COPs during the 1970s, publishing a proposed rule with opportunity for comment in 1977. More than 2,000 comments were submitted and reviewed when HCFA published revised proposed COPs in 1980. These, however, were withdrawn by the Reagan administration in January 1981. Revised hospital COPs were again published as a proposed rule in 1983 and then as a final rule in 1986. A comprehensive revision was proposed in December 1997 but has not yet been issued as a final binding rule (HCFA 1997a, HCFA 1998d).²³ HCFA received approximately 60,000 public comments in response to this proposed revision (HCFA 1999). The most recent revisions to the hospital COPs and those for other facilities stem not only from developments in quality efforts in the private sector, but also from HCFA's efforts to eliminate unnecessary procedural requirements.

Updating the COPs must also compete for attention and resources with other agency priorities. Unless the changes are mandated by the Congress, revisions and

updates to the COPs are done under HCFA's general authority to promulgate regulations. However, HCFA must address many other issues as a result of congressional directives, including a range of program and payment system changes—such as establishing prospective payment systems for a number of different provider types—contained in the Balanced Budget Act of 1997 and the Balanced Budget Refinement Act of 1999. When it sets priorities, HCFA must place mandates before discretionary issues.

MedPAC is concerned and disheartened by the infrequency with which HCFA has been able to update the Medicare COPs. This failure leaves the Medicare program without the benefits of the many advancements in quality measurement and clinical practice that have been made in the past decade, and, for some facility types, in the past three decades. It is the Commission's hope that a statutory mandate for periodic review of the COPs, perhaps no less frequently than every five years, would compel both the agency and the Congress to make this a priority. Rejuvenation of the standards could benefit the provider community by removing potentially outdated requirements and fully reflecting changes in the industry. It also could help beneficiaries by assuring their providers are held to current quality standards.

The Commission further believes that the periodic review and update of the COPs should be done through the negotiated rulemaking process.²⁴ The negotiated rulemaking process requires the participation of interested parties and the use of a convener to help the parties reach consensus. Use of negotiated rulemaking

21 Later that year, however, the Balanced Budget Act of 1997 required that payment for home health agencies be moved to a prospective system. In light of the complications surrounding this shift in payment systems, HCFA chose to implement only those revisions to the COPs that provided needed information for the new prospective payment system, in an effort to not overburden the industry. The remainder of the proposed revisions will be implemented later.

22 For example, under relevant executive orders and congressional mandates, agencies must include a regulatory impact statement with all proposed rules. This statement can include: an assessment of the costs and benefits of regulatory alternatives; a regulatory impact analysis of all rules that will have "significant economic effects"; an assessment of anticipated costs and benefits for rules that have large impact on state, local, or tribal governments, or the private sector; an analysis of options for regulatory relief for small businesses; and an analysis of the impact on the operations of small rural hospitals.

23 Two sections of the proposed COPs were carved out and implemented on an accelerated time frame. These amendments were related to patient's rights and organ, tissue, and eye procurement, which were both seen as pressing needs. (HCFA 1998c, HCFA 1999).

24 Under the Negotiated Rulemaking Act (5 U.S.C. §§ 561-570), federal agencies may develop proposed rules through negotiation with interested parties. The Act aims to enable agencies to use innovative methods to enhance the rulemaking process.

RECOMMENDATION 4D

The Congress should require that the Secretary annually survey at least one-third of each facility type to certify compliance with the conditions of participation. The Secretary should also monitor facilities' compliance with conditions of participation on an ongoing basis.

In the recent past, the total number of participating facilities has grown while the overall number of surveys conducted by state survey agencies has dropped. Table 4-3 shows trends in the number of Medicare participating facilities. The number of participating facilities grew 20 percent between 1995 and 1999. The amounts appropriated for survey and certification activities during this period also grew by 20 percent.²⁷ However, during this same period, the number of initial and recertification surveys done by states dropped by 17 percentage points, from 65 to 48 percent.

The Commission is concerned with the infrequency with which most providers are surveyed, and considered recommending mandatory periodic surveys for all facilities. At the same time, we would like to allow HCFA and the states the flexibility to target at-risk facilities and to reduce the burden on providers with good track records.

By recommending an annual survey of at least one-third of each facility type, HCFA and the states can target those facilities determined to be at risk for quality problems, thus maximizing the funds expended on this activity. HCFA should also have a mechanism for monitoring quality on an ongoing basis, perhaps incorporating a less comprehensive survey or non survey-based approach, to help it identify poor-performing facilities to target for full surveys. As a safeguard, however, the

could facilitate and consolidate the process of gaining public input, allowing interested parties to meet and discuss controversial aspects of a regulatory system. Moreover, negotiated rulemaking would give participants active voices in the process, allowing for a level of buy-in lacking in the current, more traditional method. In addition to facilitating the development and revision of the COPs, the negotiated rulemaking process might also facilitate the development of effective sanctions to assure provider compliance with quality standards.

HCFA has used a negotiated rulemaking process under mandate from the Congress to create regulations in several controversial areas in the recent past, including solvency standards for provider sponsored organizations, the ambulance fee schedule, and Medicare coverage policies for clinical laboratory services.

Some would argue, however, that the extended process through which COPs are implemented has a positive rather than a negative effect on the outcome. They believe that the current process allows for careful contemplation of the various options and needs of the program, and that the opportunity for continuous input is afforded through agency contacts with the public.

The Commission had some hesitation in mandating the use of negotiated rulemaking in all cases, concerned that HCFA needed flexibility in this arena. However, the Commission feels a strong statement is needed, given concerns about the inadequacy of the current process and its inability to keep up with industry changes. HCFA should ensure representation of all interested parties, including industry, practitioners, beneficiaries, and states. Special steps may be necessary to ensure adequate beneficiary representation. It is also

important to note that HCFA will require significant additional resources to comply with any mandate to periodically update the COPs.

Problems with certifying compliance

The original Medicare legislation required HCFA to contract with states to conduct Medicare certification surveys, enabling the Medicare program to benefit from the expertise and structure of state licensing agencies.²⁵ However, a number of problems arise from this arrangement and how it is currently funded. Surveys for many types of facilities are performed on an infrequent basis, for reasons including inadequate funding levels and a problematic process for garnering funds. The process and its results can be inconsistent and can fail to identify poor performers because of a lack of information on actual performance.

Insufficient frequency of surveys

Under current funding and legal requirements, most facilities are surveyed on an increasingly infrequent basis. HCFA directs state survey agencies to conduct yearly certification surveys on approximately 15 percent of non-hospital, non-LTC facilities, which means an individual facility is surveyed once every 7.5 years (MacTaggart 1999).²⁶ Only LTC facilities and home health agencies are surveyed on a more regular basis, due to a legal mandate that requires LTC facility surveys every year and home health agency surveys every three years. Surveys of other types of facilities are not on any legally mandated schedule.

25 Technically, a state agency's certification that a provider or supplier meets Medicare conditions of participation represents a recommendation made to the Secretary. Only the Secretary has the authority to make the "initial determination" as to whether Medicare program requirements are met.

26 These facilities include psychiatric hospitals, renal dialysis facilities, hospices, ambulatory surgical centers, rural health clinics, physical therapy providers, portable X-ray providers, and comprehensive outpatient rehabilitation facilities (HCFA 1998b).

27 Despite the coincidence of a 20 percent growth in facilities and a 20 percent growth in appropriations, it is important to note that the increased funding still supported only infrequent surveys of facilities.

**TABLE
4-3**

**Numbers of facilities participating in Medicare,
fiscal years 1995–2001**

Facility type	Fiscal year						
	1995	1996	1997	1998	1999	2000	2001
LTC facilities	13,302	14,114	14,741	15,025	14,996	16,249	16,310
HHAs	9,090	9,816	10,689	9,386	9,011	9,500	10,153
Non-accredited							
hospitals	1,409	1,422	1,412	1,426	1,431	1,450	1,310
Accredited hospitals	4,980	4,858	4,780	4,732	4,737	4,587	4,552
Dialysis facilities	NA*	NA*	NA*	NA*	3,583	3,981	3,930
Other non-LTC							
facilities	13,302*	13,931*	16,931*	17,455*	12,771	14,876	14,778
Totals	42,083	44,141	48,553	48,024	46,529	50,643	51,033

Note: LTC (long-term care), HHAs (home health agencies), NA (not available). Numbers for fiscal years 2000 and 2001 are projections.
*For fiscal years 1995–1998, dialysis facilities are included in “Other non-LTC” category.

Source: Health Care Financing Administration.

Congress should mandate that every facility undergo a full survey at least every five years or within some other reasonable time frame.

The current legal mandate for periodic surveys of home health agencies and LTC facilities arose from the Congress’ concern with quality problems. The Congress could consider allowing flexibility in the mandated survey schedule for these providers if ongoing quality monitoring proves successful.

Inadequate funding levels

Many believe that funding for state survey and certification responsibilities has been inadequate for years (Morris 1999). Such funding is garnered through the yearly appropriations process, which is subject to a range of political pressures. Appropriations have increased with the increase in participating providers, but

still only support infrequent surveys of certain provider types (Table 4-4). Greater funding levels are required to support more frequent surveys.

RECOMMENDATION 4E

The Secretary should request, and the Congress should appropriate, adequate levels of funding for survey and certification activities to enable HCFA and state survey agencies to increase the frequency of inspections and take other steps to strengthen the quality oversight process.

Appropriation of more funding is the most straightforward way to assure greater survey frequency. Other changes also could lead to higher funding levels. The method of funding could be switched to one that is less politically charged than the appropriations process—direct funding through the Medicare trust funds.²⁸ HCFA

has also suggested—but the Congress has not adopted—allowing the agency to collect user fees from entities seeking Medicare certification.²⁹

The Commission strongly believes that HCFA and the Congress should take responsibility for adequately funding survey and certification activities through the normal appropriations process. Switching the funding method for these responsibilities merely avoids addressing the issue; in addition, MedPAC does not believe that direct funding is an appropriate response to the problem of inadequate funding. MedPAC also sees no benefit to providers in assessing user fees for quality oversight activities.

While MedPAC acknowledges that funding levels are problematic, it remains concerned that the underlying substance of the standards, and the process for applying those standards, are flawed. Additional funds may be useful but will not necessarily repair those flaws. Moreover, it is difficult to state what an adequate funding level would be for such activities. HCFA is only now in the process of conducting a focused assessment of the necessary costs associated with surveys of the various facility types (Pelovitz 2000).

Increased funding is not the sole answer. For example, problems in nursing facilities persist, despite recent increases in funding and stepped up oversight activities (Table 4-5) (Meyers 1999, Miller 1999, Edelman 1999). This increased focus is likely due to several factors, including the attention given in the press to poor nursing home conditions, the fact that LTC facilities make up the bulk of Medicare participating facilities, and the congressional mandate for yearly surveys of these entities. Some complain

28 The Professional Standards and Review Organization program experienced similar funding problems during its tenure and was unable to achieve adequate results due to low funding levels. When that program was legislatively revamped in the early 1980s into the Peer Review Organization program, the funding method was switched from congressional appropriation to direct funding through the trust funds to assure a constant and reliable funding level.

29 In each of its budget requests for the past few years, HCFA has requested authority to charge user fees to offset the costs incurred in conducting survey and certification activities. With congressional authority, the Secretary currently assesses user fees on clinical laboratories and suppliers of screening mammography services to cover the costs of inspections and other oversight. The Secretary also has authority to collect user fees from Medicare+Choice organizations to cover costs relating to enrollment and dissemination of information and certain counseling and assistance programs for beneficiaries. In its June 1999 report, MedPAC recommended against collecting user fees from Medicare+Choice organizations for these purposes. It should also be noted that facilities gaining Medicare certification through deemed accreditation organizations must pay fees to the accrediting body.

**TABLE
4-4**

Survey and certification funding levels, fiscal years 1995-2001 (in thousands of dollars)

Fiscal year	Requested	Appropriated	Direct survey costs
1995	\$145,800	\$145,800	\$141,086
1996	162,100	145,800	139,649
1997	173,800	158,000	142,274
1998	158,000	154,000	146,912
1999	104,700	175,000	167,230
2000	204,347	204,674	194,000
2001	234,147	NA	NA

Note: NA (not available). Appropriated amounts and direct survey costs for fiscal years 1999 and 2000 include amounts targeted to the Administration's Nursing Home Initiative.

Source: Health Care Financing Administration.

that oversight of LTC facilities occurs only at the expense of other types of facilities (Morris 1999).

Poor timing of funding process

The timing of the federal process for garnering funds for survey activities raises problems for states from a process perspective. As stated above, state survey agencies are dependent upon HCFA for most of their funding. Federal funds support state survey and certification activities for Medicare and Medicaid. In contrast to the Congress, many state legislatures meet less than annually, making it difficult for states to assure adequate funding levels to meet federal policy initiatives.

the resources and staff needed to meet HCFA priorities for a fiscal year without advance knowledge of funding levels (Morris 1999). Moreover, even if adequate funding levels are provided, hiring and training staff takes time, rendering it difficult for states to quickly respond to HCFA initiatives.

State funds support the survey agencies' state-only activities, such as licensing, and a portion of Medicaid survey and certification costs. A large percentage of state survey agency activities relate to Medicaid; LTC facilities make up the

largest number of participating facilities, and most LTC facilities participate in both Medicare and Medicaid (Table 4-3). This phenomenon is financially significant for the survey agencies, not only because of the large numbers of such facilities they must oversee, but also because federal law requires that these entities be surveyed on an annual basis. State funds are garnered through state appropriations processes, which for many states occurs only biennially.

The biennial or other less-than-annual schedule of state appropriations can make it difficult for survey agencies to make full use of federal Medicaid funds directed at survey activities. Federal Medicaid funds are provided to states only as the "federal match" of state funds expended.³⁰ As such, the states must know what level of federal Medicaid funding to expect to correspond their state requests to make full use of available federal matching funds. If the Congress decided to provide each state with additional funds to target certain quality activities, the states would have to know about this extra money at the time they submit their state appropriations requests to get sufficient state funds to qualify for the additional federal match. If the federal funds are made available during a year when a state's legislature does not meet, then the

RECOMMENDATION 4 F

The Congress should assure that the federal appropriations process does not impede states' abilities to fund Medicare and Medicaid survey and certification activities.

Federal funding levels for states' Medicare and Medicaid survey and certification activities is set upon passage of the yearly budget act. Inevitably, the federal budget process extends into the beginning of the relevant federal fiscal year. State survey agencies have complained that it is difficult to coordinate

**TABLE
4-5**

Spending on survey and certification activities for long-term care and other facilities, fiscal years 1993-1999 (in thousands of dollars)

Fiscal year	Long-term care	Non long-term care	Total
1993	\$82,300	\$50,900	\$133,200
1994	80,900	57,700	138,600
1995	93,400	47,700	141,100
1996	87,900	51,700	139,600
1997	98,000	44,700	142,700
1998	102,000	45,100	147,100
1999	119,200	48,000	167,200

Note: Fiscal years 1993-1995 amounts are direct survey costs; fiscal years 1996-1997 amounts are amounts awarded to states; fiscal years 1998-99 amounts are not yet final.

Source: Health Care Financing Administration.

³⁰ The Medicaid program is a joint state-federal program, funded by state expenditures that qualify states for federal matching funds. A state must spend its own monies to qualify for the federal match.

state survey agency cannot use that extra money, as there is no mechanism for revisiting its state budget until the next legislative session.

Inconsistency in certification process

Another frequent complaint about the survey process is the lack of consistency within and across state survey agencies. Surveyors vary in assessing facility compliance with the COPs and determining appropriate sanctions. Even LTC surveys vary, although surveyors use a deficiency matrix to guide the application of sanctions. In addition, there is variation in approach among HCFA regional offices, the contact points between HCFA's central office and the state survey agencies.

HCFA is pursuing a number of strategies to improve the consistency among surveyors and between state survey agencies and the Commission supports these efforts. One method to improve quality is the State Agency Quality Improvement Program (SAQIP). The SAQIP aims to evaluate the quality of survey and certification activities being performed by the survey agencies, using standards developed jointly by state agencies and HCFA regional offices (HCFA 1998a). The SAQIP is part of a larger effort aimed at achieving a consistent, accountable survey and certification process. Other pieces of this effort include federal oversight and monitoring surveys, review of the Online Survey, Certification, and Reporting system (OSCAR) data, individual reviews of certification actions, and improvements in the budget process.

In addition, HCFA is considering increasing the amount of training required of state surveyors. At present, individuals are merely required to complete an initial certification training course; HCFA is exploring the possibility of requiring surveyors to undergo recertification along with interim training efforts. The Commission also commends these efforts by HCFA.

Limited ability to identify poor performers

Because Medicare's current survey process focuses on a provider's status at one point in time, it may not be able to assess important aspects of the facility's usual operations. Measures of health care quality and measures designed to assess other aspects of providers' performance, such as their adherence to patient rights' requirements, can strengthen the oversight process. MedPAC recommends their use in three complementary ways.

RECOMMENDATION 4G

State survey agencies should use health care quality measures and other measures of facility performance to:

- **determine which facilities to survey more and less frequently,**
- **target specific issues or quality concerns for focused attention in the survey process, and**
- **monitor facility performance between inspections.**

Until recently, HCFA had limited ability to identify and target poor-quality providers for inspection. As discussed above, for providers other than home health agencies and LTC facilities, the current survey process focuses on structural elements thought to be related to the capability to furnish care of adequate quality, and can respond to poor quality only through the limited standard survey or reports of poor quality or adverse incidents. The system is not structured to monitor a provider's performance between inspections. In addition, survey agencies generally do not receive information about a provider's processes of care and outcomes before an inspection, which may hinder their ability to effectively use their limited resources to focus the inspection on problems specific to that provider.

MedPAC believes that performance measures should be used to select which facilities should be surveyed more and

less frequently. Determining frequency according to relative performance may be especially useful in improving oversight of providers with no statutory requirement for a regular inspection. Ultimately, using performance measures to identify poor-performing providers could change HCFA's inspection strategy by dedicating increased resources to surveying outlier providers more frequently, decreasing the resources dedicated to inspecting better-performing providers.

MedPAC also calls for the use of performance measures to help state survey agencies understand and engage providers in dialogues about their treatment practices during the inspection, rather than to assess only the capacity to furnish care. The short duration of an inspection limits the ability of even the best surveyor; such visits inevitably consist of brief, tightly scheduled sessions not amenable to taking a broad view of patterns and processes of care within the facility. Use of these measures may be one way to capture information more representative of a provider's usual processes of care and patient outcomes.

Finally, MedPAC recommends the use of performance measures to monitor providers' performance levels between inspections, which could potentially permit survey agencies to detect poor-quality care before a serious deficiency develops and to more effectively determine survey frequency and scope.

Problems with enforcement and sanctions

Medicare's sanctioning process is an important component of its quality assurance system because it is HCFA's primary vehicle for enforcing its COPs. The sanctioning process is limited in two important respects, however.

First, HCFA's available sanctions generally do not match the severity and scope of the cited deficiency, nor do they consider providers' inspection histories or their ownership and ability to pay. Consequently, federal sanctions have limited effectiveness to deter future

Using performance measures in Medicare certification

To improve its ability to ensure the quality of care, the Health Care Financing Administration (HCFA) is beginning to integrate performance measures into the survey and certification process for some types of providers. The agency currently uses such measures in surveys of long-term care facilities and home health agencies and is in the process of developing measures for use in surveying renal dialysis facilities.

For long-term care facilities and home health agencies, information from the Minimum Data Set and the Outcome and Assessment Information Set is being used to focus onsite inspections by identifying potential quality concerns and opportunities to improve care. Data from these reports will also be used to monitor provider performance between inspections.

Performance measures for renal dialysis facilities will be based on data from existing collection efforts,

including HCFA's annual facility survey; cost reports; death notification forms; medical evidence forms; the Online Survey, Certification, and Reporting database; and administrative claims databases.

HCFA is considering the development of similar performance measures for use in targeting and structuring state inspections of hospitals. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is developing a series of 25 performance measures for acute-care hospitals that will be used to monitor provider performance between surveys and to focus on-site survey evaluative activities. JCAHO will conduct a pilot test using a subset in five states during 2000–2001, will require all hospitals to collect data on a subset of the measures by 2002, and by 2003 will require hospitals to collect data on all of the measures within the selected sets to obtain JCAHO accreditation. ■

imposing civil money penalties, suspending payments, and appointing temporary management—are available to sanction only certain institutional providers, such as home health agencies and LTC facilities.

RECOMMENDATION 4H

The Congress should authorize the Secretary to develop intermediate sanctions specific to each institutional provider type that reflect the scope and severity of the deficiency and to consider a provider's past performance in levying sanctions.

Because of the lack of intermediate remedies for most institutional providers, compliance with Medicare's COPs is often contingent upon the threat of Medicare termination. The threat of Medicare termination is an ineffective means of ensuring future compliance with HCFA's COPs, however, because only those providers with serious and life-threatening deficiencies can be terminated from the Medicare program. Indeed, only a few institutional providers lose Medicare certification; for example, only 4 skilled nursing facilities and 10 home health agencies were terminated from Medicare for the most recent 12-month period available (Feb. 1999 through Jan. 2000) (OIG 2000a). No hospitals or renal dialysis facilities were terminated during this period.

Among all institutional providers, the sanctions for LTC facilities offer the most flexibility in matching the deficiency with the sanction because they are based on the severity and scope of the deficiency.³² Required and optional sanctions are assigned based on the deficiency's severity category (actual or potential for death/serious injury, other actual harm, potential for more than minimal harm, potential for minimal harm) and scope (isolated, pattern, and widespread). No other provider type has sanctions defined in this way.

noncompliance with HCFA's COPs. MedPAC offers one recommendation to develop intermediate sanctions that may promote long-term adherence to COPs.

Second, certain procedures limit HCFA's ability to impose sanctions, including its lack of authority to impose sanctions on an immediate basis without a grace period, the referral process for deficiencies discovered during complaint investigations, and the current backlog in the appeals process. The Commission encourages the Secretary to study ways to improve the process of imposing sanctions, including improving the management information systems that will

support new initiatives to strengthen the effectiveness of the enforcement process.

Limited range of sanctions available

HCFA's available sanctions provide few incentives to ensure providers' long-term compliance with COPs because available remedies do not generally reflect the scope and severity of the deficiency or take into account previously cited deficiencies and sanctions. The Secretary can terminate from Medicare any institutional provider not in substantial compliance with its COPs.³¹ However, intermediate remedies—including

31 Specific sanctions that can be imposed upon some providers are set forth in the Social Security Act. Additionally, if a PRO submits a report to the Secretary documenting a provider's poor-quality care, the Secretary has the option to either impose civil monetary penalties or terminate the provider from Medicare (Soc. Sec. Act §1156).

32 The Omnibus Budget Reconciliation Act of 1987 gave the Secretary authority to specify criteria on when and how each sanction for long-term care facilities should be applied.

We recommend that HCFA develop intermediate sanctions for other institutional providers that match the scope and severity of the deficiency. For certain types of hospitals and renal dialysis facilities, HCFA is proposing intermediate sanctions—such as denial of payment—as alternatives to terminating coverage when the deficiencies do not pose immediate jeopardy to patient health or safety. These proposed intermediate sanctions represent a step in the right direction, providing HCFA with increased flexibility to sanction providers. However, their effectiveness may still be limited because they do not consider the scope and severity of the deficiencies. In addition, provider characteristics, such as ability to pay, may cause intermediate sanctions to affect providers differently.

Currently, HCFA considers past performance only in assessing LTC facilities, designating a facility as a “poor performer” if they meet the required criteria of past deficiencies. For other institutional providers, past performance is generally not considered, even among those that have been repeatedly cited for deficiencies. Additionally, even among providers terminated from the Medicare program, there is no requirement to consider their deficiency histories once they re-enter the Medicare program.³³

We call upon HCFA to consider a provider’s past performance in levying sanctions because past performance often predicts future adherence to HCFA’s COPs. Among nursing homes cited for severe deficiencies, 40 percent were cited for deficiencies at the same or a higher level of severity during subsequent inspections (GAO 1999). The current enforcement process neither rewards providers for substantially improving performance, nor imposes more severe remedies for providers with consistent

deficiencies. Because past performance is not considered, there are no incentives in the enforcement process to ensure long-term compliance with Medicare’s COPs.

Finally, Medicare needs to address whether rewarding certain providers’ performances would improve long-term compliance with its COPs. These providers include those who consistently meet and exceed the COPs and providers who significantly improve their adherence to the COPs. Possible incentives include designating excellent providers in comparative materials provided to help beneficiaries make selection decisions and linking Medicare payments to quality findings through a performance-based payment system. The program also might find a way to relieve exceptional performers from some of the burden of demonstrating compliance, perhaps by reducing the frequency or scope of recertification surveys.

Unwieldy process of imposing sanctions

In addition to the limited scope of available sanctions, certain procedures limit HCFA’s ability to impose sanctions and the effectiveness of sanctions. These include HCFA’s lack of authority to impose sanctions on an immediate basis without a grace period, the referral process for deficiencies discovered during complaint investigations, and the current backlog in the appeals process.

Because a grace period (usually 30 to 60 days) is given to most providers with histories of deficiencies, the enforcement system provides few incentives for long-term adherence with HCFA’s COPs.³⁴ With the exception of LTC facilities, HCFA is required by statute to impose a sanction for most deficiencies only after a grace period, even for providers with a history of deficiencies. Even using

intermediate sanctions cannot ensure long-term adherence if providers with a history of deficiencies are able to use a grace period to rectify deficiencies. In a study of nursing home quality assurance methods, the GAO concluded that although the threat and use of sanctions—even intermediate sanctions—achieve temporary corrective action, they do not ensure long-term compliance with COPs (GAO 1999). In its study of home health quality assurance methods, the GAO noted that home health agencies subvert the termination process by taking temporary corrective action (GAO 1998).

Medicare needs to address the problem that HCFA cannot impose sanctions without the benefit of a grace period for institutional providers with histories of deficiencies. This would require developing the necessary criteria to classify “poor performers” that can be sanctioned without the benefit of a grace period. Eliminating grace periods for providers with histories of deficiencies may help encourage sustained compliance because these providers are more likely to be affected by penalties. Ultimately, this action would strengthen the effectiveness of the enforcement process and encourage all providers to adhere to Medicare’s COPs over the long term.

Another way to strengthen the sanctioning process is to consider sanctioning for deficiencies originally cited during complaint investigations; currently, such deficiencies that are rectified by the time of the investigation are usually considered “past noncompliance” and are not referred for immediate sanction.³⁵ The GAO found examples where serious life-threatening deficiencies in nursing homes were not cited as such because they were resolved by the time of the investigation (GAO 1999).

33 Generally, a provider that is terminated from the Medicare program can apply for reinstatement if it corrects its deficiencies.

34 In general, providers that do not meet one or more conditions of participation may submit a plan of correction and address the cited deficiencies during a grace period (usually a 30- to 60-day period) (42 CFR§488.28). Survey agencies do not refer providers for sanction unless they fail to correct their deficiencies within the grace period.

35 Beneficiaries may submit complaints to state survey agencies, the PROs, and the ESRD networks. In investigating complaints, the PROs and the networks do not assess providers’ compliance with Medicare’s COPs, but determine whether they are furnishing care that is medically necessary, appropriate, and of adequate quality. The PROs and networks can recommend that deficient providers adopt a corrective action plan. The PROs and the networks are only required to submit to the Secretary sanction recommendations on providers with substantial violations in a number of cases or a gross and flagrant violation in one or more cases.

The current large backlog of provider appeals may impede HCFA's ability to impose sanctions. Once the OIG imposes a sanction, providers may appeal the decision first to a Department of Health and Human Services (HHS) administrative law judge, then to the HHS Departmental Appeals Board, and finally to the federal district court. The GAO suggested that this process undermines the effectiveness of sanctions by pressuring HCFA to resolve the appeal by negotiating settlements (GAO 1999). Medicare needs to develop ways to allow due process without stripping sanctions of their effectiveness.

Finally, the current management information system needs to be improved to support key HCFA quality assurance initiatives. Successful implementation of MedPAC's recommendation on considering providers' histories of deficiencies and characteristics in sanctioning is dependent upon an information system that can track

deficiencies and sanctions over time, as well as track providers' ownership statuses. The GAO has found three major deficiencies in HCFA's management information system: its inability to track enforcement actions centrally, the lack of needed data on the results of complaint investigations, and the inability to identify facilities under common ownership (GAO 1999). Initiatives to improve and strengthen the sanction process cannot be effectively imposed until these problems are rectified.

Problems with Medicare deeming

A number of facility types can be deemed to meet Medicare certification standards through private accrediting entities. Table 4-6 lists facility types that currently can gain Medicare certification through accreditation, and the private organizations endowed with that deeming authority. Deeming authority is generally granted by HCFA, although JCAHO's deeming authority was statutorily granted

by the Congress. This reliance on accrediting organizations allows HCFA to take advantage of outside expertise and potentially lessens the cost to Medicare of conducting quality assessment. However, private accreditation has moved in large part toward QI rather than QA, and may be neglecting the baseline assurances to be gained from Medicare's certification system. The Commission believes that HCFA must maintain ongoing oversight of and involvement with private entities, to ensure they are holding facilities to Medicare's baseline quality standards.

RECOMMENDATION 41

The Secretary should take additional steps to ensure that private accrediting organizations with Medicare deeming authority are, in fact, ensuring that facilities meet Medicare certification standards.

Reliance on private accrediting organizations to certify facilities' compliance with Medicare certification

TABLE 4-6

National accrediting organizations with Medicare deeming authority

Facility type	Entities with deeming authority	Date(s) authority was granted or renewed
Hospitals	Joint Commission on Accreditation of Healthcare Organizations (JCAHO) The American Osteopathic Association (AOA)	Jul. 1965 1966, Feb. 2000
Home health agencies	Community Health Accreditation Program (CHAP) JCAHO	May 1992 Jun. 1993
Clinical laboratories	Committee on Laboratory Accreditation JCAHO The American Association of Blood Banks AOA The American Society for Histocompatibility and Immunogenetics College of American Pathologists	Dec. 1993, May 1997 Jan. 1995, Apr. 1998 Jul. 1995, Apr. 1998 Jul. 1995, Apr. 1998 Oct. 1994 Feb. 1995
Hospices	JCAHO CHAP	Jun. 1999 Apr. 1999
Ambulatory surgical centers	JCAHO Accreditation Association for Ambulatory Health Care American Association for the Accreditation of Ambulatory Surgery Facilities, Inc.	Dec. 1996 Dec. 1996 Dec. 1998

Source: MedPAC review of Federal Register issuances.

standards has great appeal, from both the government and the private industry perspectives. It prevents duplication of efforts by private and public entities, lessening their burden. However, many have criticized HCFA's lack of oversight of these organizations' Medicare survey activities. Much of this has focused on HCFA's oversight of JCAHO's program for accrediting hospitals (Dame and Wolfe 1996, Jost 1994, OIG 1999a-d).

One of the most serious criticisms raised by the OIG was the congenial nature of the relationship between JCAHO and the hospitals (OIG 1999b). This criticism could apply equally to other accrediting entities that see themselves more as QI organizations than as QA mechanisms, and thus encourage a congenial relationship with the facilities they survey. The Community Health Accreditation Program (CHAP), which has deeming authority for home health agencies and hospices, describes itself as "the leader in improving quality of care in the home care industry" and identifies its goal as helping home care to not only prosper, but also gain strength in the overall health care industry. To achieve this, CHAP states that it is devoted to providing consultation of the highest caliber (CHAP 2000). Other deemed status organizations make similar statements about their focus on QI, not QA. The Accreditation Association for Ambulatory Health Care (AAAHC), which has deemed status for accreditation of ambulatory surgical facilities, emphasizes its cooperative, consultative role in the certification process, stating that it emphasizes "constructive consultation and education," not "finding fault" (AAAHC 2000). Although these organizations participate in the QA process, their educational focuses do not necessarily reflect the regulatory approach that has been the basis of QA.

HCFA has only limited mechanisms to oversee the activities of deemed organizations. When it grants deemed status, HCFA assesses the standards and processes used by an accrediting body to

determine that they are at least equivalent to the Medicare standards and assessment methods. HCFA then has state survey agencies conduct limited validation surveys to ensure adequate performance. Deemed organizations' standards and processes are reviewed by HCFA every six years to ensure equivalence with Medicare.

In contrast, JCAHO's status as a deeming organization for hospitals is statutorily mandated. Therefore, HCFA cannot revoke JCAHO's authority. However, the agency can stay informed of JCAHO standards and use its influence to focus public attention on any concerns. In fact, JCAHO standards and HCFA standards have diverged in focus and approach over the years, with JCAHO moving more toward outcomes measurement rather than structure and process assessment.³⁶ For example, HCFA recently amended the hospital COPs to add a provision on the use of patient restraints. JCAHO, however, expressed reservations about adding this provision to its standards. Given the public interest in such patient rights issues, HCFA and JCAHO are negotiating how to address this divergence.

The Commission believes that HCFA should make additional efforts to monitor the activities of private accrediting bodies. Increasing use of validation surveys is one approach for doing so. Limited validation surveys are conducted to assess JCAHO's performance in this area, but only 5 percent of the more than 4,500 accredited hospitals participating in Medicare will undergo such a survey during fiscal year 2000. However, state survey agencies are already dealing with a variety of burdens and may not be able to fully respond to increased levels of validation surveys. Another approach HCFA could take would be to pursue informal contacts and meetings with accrediting entities to keep current on the status of developing standards and survey processes.

Problems with the availability of consumer information about Medicare's survey and certification process

At issue is the extent to which HCFA should make available to consumers information about Medicare's survey and certification process. Currently, Medicare provides consumer-based information on: the costs, benefits and quality of care in traditional Medicare and specific Medicare+Choice plans, and the structural characteristics of specific nursing homes, selected medical characteristics of their residents, and selected results of their most recent survey inspection.

RECOMMENDATION 4J

The Secretary should make more information about the results of the survey and certification process available to beneficiaries.

There is a clear trend to promote more active consumer participation in health decisions. Consumers are interested in having access to information about health care providers, and proponents believe that this information facilitates more informed health care choices. Consumer-based information can facilitate active involvement of consumers in their own health care and the health care system and can, in particular, support decisions about providers, facilities, or types of setting. Ultimately, the availability and use of such data may lead to consumers having greater confidence in the health care system overall, and poor-performing providers either improving or leaving the market.

Consumer-oriented information about the nursing home quality assurance process is available from an interactive Web site known as "Nursing Home Compare" (HCFA 2000). The site provides facility-specific information, derived from the OSCAR system, about the total number of deficiencies the facility reported by state inspectors during the most recent

³⁶ This raises potential problems. In her testimony before MedPAC, Oregon's manager of health care licensure and certification told of hospitals that, while undergoing Medicare validation surveys, expressed the belief that they did not need to meet Medicare's COPs because they were accredited by JCAHO.

inspection, a description of each deficiency, the date the deficiency was corrected, and the scope and severity of the problem. The nursing home web site, however, does not include information about a facility's deficiencies cited in prior inspections, which prevents consumers from being able to assess a facility's performance over time, nor does it provide information on whether and how a facility was sanctioned for cited deficiencies or whether a facility has ever been terminated from the Medicare program under its current owner.

MedPAC recommends that the Secretary provide beneficiaries with more information about the results of the survey and certification process for individual providers. For the nursing home web site, the Secretary should provide information on facilities' previous inspection results as well as current and previous sanctions levied on facilities, including whether the facility was ever terminated from the Medicare program under its current ownership.

HCFA has plans to develop web sites with information about other types of

providers, including home health agencies and renal dialysis facilities. The proposed measures for the renal dialysis facility web site would not require that information about any aspect of the survey and certification process other than the date of the most recent survey inspection be provided, however. As the agency develops these web sites to provide beneficiary information about home health agencies and renal dialysis facilities, similar information about providers' current and past deficiencies and sanctions should be included to the extent possible. ■

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