
NURSING HOME REGULATION AND FUNDING:

A Resident-Oriented Approach

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Executive Summary

Congressional hearings, governmental reports, and newspaper headlines paint a bleak picture of the care that nursing homes give their clients. After hearing testimony about the state of nursing homes in Tennessee, the chairman of a subcommittee of the House Human Resources Committee asked the Office of the Comptroller to prepare a report reviewing the adequacy and enforcement of nursing home quality of care standards and related issues. This examination considered a variety of matters, including laws and administrative rules governing the regulation of facilities, nursing home inspection practices, Tennessee's use of sanctions against substandard nursing homes, data insufficiency, methods used to protect nursing home residents against abuse and neglect, and the Medicaid reimbursement method used by the state.

The Health Care Financing Administration (HCFA) issues federal regulations and program guidance for nursing homes and other health care facilities, but contracts with state agencies to inspect, or survey, nursing homes to determine compliance with those regulations. In Tennessee, the state survey agency is the Department of Health, Division of Health Care Facilities. The Division inspects a total of 353 nursing homes for compliance with HCFA standards and state licensing regulations and another six solely for licensure purposes.

In recent years, HCFA has responded to nationwide concerns about conditions in nursing homes by placing additional requirements on both nursing facilities and state survey agencies through its Nursing Home Initiative, an effort to ensure quality care. The Initiative is evolving with new mandates introduced periodically to crack down on nursing homes that repeatedly violate rules that affect patient well-being.

This report includes findings and recommendations in several areas, including:

Inspection and investigation practices. See pages 9-14.

- The percentage of nursing homes in Tennessee with serious deficiencies increased after the federal Nursing Home Initiative began. Because of nationwide concerns about conditions in nursing homes, in recent years the federal government has placed more stringent requirements on both nursing homes and state regulators.
- Nursing home officials can generally predict when surveys will be conducted. According to a recent Government Accounting Office study, 56.1 percent of Tennessee's surveys were conducted within one year and fifteen days of the previous survey.
- The Division of Health Care Facilities does not always comply with federal timeframes for investigating complaints against nursing facilities. The Division has requested additional staff to respond to complaints.
- A relatively few number of facilities account for the majority of complaints. According to 1999-2000 complaint data, approximately 16 percent of facilities accounted for approximately 50 percent of complaints and unusual incidents.

Deficiency Correction. See pages 14-24.

- Although HCFA has federal oversight responsibilities for nursing facilities, responsibility for correcting deficiencies in substandard facilities lies with the state.

Unless the Division of Health Care Facilities focuses more on post-survey activities, patterns of substandard care may continue within the protocols established by HCFA.

- The corrective component of the survey process, which involves the preparation and approval of a plan of correction, is often ineffective. Sometimes the correction of a deficiency becomes less important to a nursing facility than defending itself against a monetary sanction.
- The lack of frequent presence by state officials in nursing homes results in sporadic enforcement of standards. Additional staff, in the form of facility monitors, could conduct spot checks of facilities and alert surveyors when conditions warrant a more thorough inspection.
- Federal and state monetary penalties do not encourage immediate correction of deficiencies nor do they lead to long-lasting changes. This punitive approach to enforcement often results in the diversion of significant facility and government resources from activities that could improve quality of care.

Data management. See pages 24-25.

- The department collects and maintains a significant amount of data related to nursing facilities. More thorough analysis of that data could contribute to more efficient and effective administration, e.g., by allowing the department to focus on facilities with recurring problems.
- In addition to contributing to administrative efficiency, regular data analysis and reporting would help corroborate or refute much of the testimony regarding nursing facilities that is presented to the General Assembly.

Nursing home staffing. See pages 26-32.

- Although Tennessee's nursing homes generally meet state staffing standards, they do not always employ enough staff to ensure quality of care. Tennessee's regulations require a minimum of two hours per patient per day, including time for both nurses and nurses' aides.
- Compared to the rest of the United States, Tennessee has greater percentages of nursing home residents with higher acuity levels, needing more staff time and monetary resources to meet their needs.
- Tennessee's training to certify nursing assistants does not lead to continued career development. The result has been system-wide staffing shortages, high turnover rates, and under-trained staff.

Financial concerns. See pages 32-36.

- **Liability Insurance.** Liability insurance costs for nursing homes have risen dramatically, due in part to increases in lawsuits in other states claiming negligent care.
- **Bed Tax.** HCFA has ruled that Tennessee's "bed tax" is impermissible. Tennessee has joined several other states to appeal the ruling. The bed tax is a significant funding mechanism for nursing homes, providing annual revenue of about \$104 million. The tax is imposed as a method of enhancing federal funding for the state's TennCare nursing home program.

- **Intergovernmental Transfers.** HCFA has proposed a rule to limit the use of intergovernmental transfers, another funding mechanism. Tennessee was able to leverage approximately \$75 million from the federal government in fiscal year 2000 and again in fiscal year 2001.
- **Management Fees.** Current reimbursement rules allow non-related nursing home management companies to receive payments that in some cases are not directly related to the services they provide.
- **Reimbursement method.** Medicaid nursing home reimbursement expenditures for fiscal year 2000 were \$759 million (state and federal dollars). The current reimbursement method includes several rate components (e.g., the cost increase factor, the cost containment incentive, and return on equity) that are not directly linked to quality care. A reimbursement method that provided incentives for direct patient contact personnel could improve quality of care.

Licensure and Certificate of Need. See pages 36-38.

- Although Tennessee law provides for the suspension or revocation of licenses, the process for renewing nursing home licenses does not consider a facility's failure to provide quality care. Facilities merely pay an annual fee and the Division renews the license.
- The Certificate of Need process in Tennessee does not ensure that facilities will provide quality care. The Health Facilities Commission does not always have information needed to consider quality of care issues.

Role Coordination. See pages 38-40.

- In Tennessee, authority and responsibility for overseeing the health care industry rests with multiple agencies, resulting in an uncoordinated, duplicative, and sometimes uncooperative and conflicting, system of care to vulnerable senior citizens. Persons interviewed for this report described several processes that result in a duplication of effort or in ineffectual attempts to perform their duties.

Recommendations begin on page 41. Legislative recommendations include measures to restructure state agencies having regulatory or investigative functions and to revise the nursing home reimbursement formula. Administrative recommendations address data management, sufficiency of survey staff, deficiency corrections, and agency roles. Agency comments and Office of Research responses are located following individual recommendations.

Introduction

Approximately 39,000 elderly and disabled Tennesseans reside in the state's 359 nursing facilities. Nationally, about 1.6 million citizens reside in about 17,000 facilities.¹ For some residents, the facilities are expected to be alternate homes, where minimal services help them maintain lifestyles similar to the ones they experienced in their own homes. For other residents, the facilities resemble extended-stay hospitals, where significant medical service is necessary. Federal and state agencies, as well as taxpayers, expect nursing facilities to fulfill these various roles, and to do so to a high standard. However, recent Congressional hearings, governmental reports, and newspaper headlines paint a bleak picture of the care that nursing homes provide to their residents. Other reports illustrate an industry in crisis, facing bankruptcies and lawsuits, nursing and other staff shortages, and interruptions in service.

Spokesmen for the nursing home industry told Comptroller's staff that "keeping everyone happy" is one of their greatest challenges. They explained that nursing homes have multiple customers (e.g., residents, family members, federal and state governments) and that family members are usually the hardest to satisfy. Watching a loved one reach the "end of life" stage can be an emotional, guilt-ridden experience that often leads to unrealistic expectations about the patient's medical care. Family members often blame the facility for any decline in the resident's condition rather than accept the patient's ill health. Some family members expect the patients to receive one-on-one care and to have all needs attended to immediately, which is impractical given staff shortages in most nursing homes. Nursing homes can be caught in the middle between patients, family members, and doctors when one party does not respect the opinion or decision of another.

Both federal and state taxpayers contribute significantly to the cost of care for nursing facility residents. Medicaid expenses for nursing facilities in Tennessee have risen steadily over the last decade. In fiscal year 1999-2000, state and federal dollars totaled approximately \$759 million.² A complex system of oversight and enforcement attempts to ensure that nursing facility residents receive quality care, and that taxpayers receive fair value for their tax dollars. The economic implications for individuals and for governments are obvious and significant.

¹ HCFA Fact Sheet, September 28, 2000. *Assuring Quality Care for Nursing Home Residents*.

² Medicaid/TennCare Section, Division of State Audit.

The following table shows Medicaid expenditures for nursing homes in Tennessee (federal and state dollars combined) for fiscal years 1992-93 through 1999-2000.

Exhibit 1

Medicaid Nursing Home Expenditures (millions of dollars)				
Fiscal Year	Level 1	Level 2	Total	Growth
1992-93	\$446.0	\$59.6	\$505.6	
1993-94	\$470.4	\$63.0	\$533.4	5.50%
1994-95	\$499.1	\$68.3	\$567.4	6.37%
1995-96	\$529.0	\$78.5	\$607.5	7.07%
1996-97	\$542.8	\$86.9	\$629.7	3.65%
1997-98	\$580.6	\$92.4	\$673.0	6.88%
1998-99	\$612.2	\$97.4	\$709.6	5.44%
1999-00	\$650.5	\$108.4	\$758.9	6.95%
Note: Expenditures include state and federal dollars; exclude patient liability.				

Source: Compiled by Medicaid/TennCare Section, Division of State Audit.

Reliance on health care services for the elderly will increase over the next several decades. By 2010 the percentage of population aged 65-85 will be higher in the South than in any other region (13.8 percent). This will continue at least through 2025, when 20 percent of the South's population will be elderly.³ As indicated by Exhibit 2 below, Tennessee will follow the population age distribution trend of other southern states.

Exhibit 2

Tennessee's Projected Total & Elderly Population			
Year	Total	Age 65-85	% of Total
2000	5,657,161	706,797	12%
2005	5,965,611	759,070	13%
2010	6,180,274	844,947	14%
2015	6,364,850	993,354	16%
2020	6,528,653	1,166,173	18%
2025	6,664,922	1,355,295	20%

Source: Compiled by Comptroller's staff from Bureau of the Census data (<http://www.census.gov/population/projections/state>).

The increase in the percentage of elderly population will also contribute to an increase in the "dependency ratio," which is the ratio of the young (below 20 years of age) and old (above 65 years of age) to the working population (between 20 and 65 years of age).⁴

³ [Http://www.census.gov](http://www.census.gov).

⁴ [Http://www.census.gov](http://www.census.gov).

The following table shows patient days for which nursing facilities received Medicaid reimbursement for fiscal years 1992-93 through 1999-2000. Although total patient days are projected to decline, total costs are projected to continue to increase. (See Exhibit 1.)

Exhibit 3

Medicaid Nursing Home Patient Days					
Fiscal Year	Level 1	Growth	Level 2	Growth	Total
1992-93	8,795,481	2.13%	659,640	2.09%	9,455,121
1993-94	8,756,782	-0.44%	662,193	0.39%	9,418,975
1994-95	8,785,982	0.33%	662,008	-0.03%	9,447,990
1995-96	8,772,700	-0.15%	718,007	8.46%	9,490,707
1996-97	8,701,123	-0.82%	754,707	5.11%	9,455,830
1997-98	8,732,833	0.36%	774,230	2.59%	9,507,063
1998-99	8,798,809	0.76%	809,708	4.58%	9,608,517
1999-00 (*)	8,717,194	-0.93%	853,027	5.35%	9,570,221
Note: (*) projected					

Source: Compiled by Medicaid/TennCare Section, Division of State Audit.

Demographic trends indicate that the need for long-term residential care for the elderly will increase dramatically in the next 20 years. Most likely this need will not be met by the traditional nursing facility alone, but also will be addressed by assisted living centers, residential communities for the elderly, home and community-based care providers, and special-needs facilities. Nursing facilities may become more specialized and serve residents, or patients, of specific acuity levels.

Perhaps less obvious, but no less significant, are the social, moral, and psychological implications that arise as individuals attempt to understand, and navigate, the elder-care systems that are available to them. The issue of the quality of care in nursing homes is not limited to Tennessee. Every state has come under federal scrutiny; many have taken the initiative to examine their own systems. No state system has presented itself, or been cited by any other group, as exemplary.

During the 2000 session of the General Assembly, legislators passed a resolution urging the Commissioner of Health to develop a quality care incentive plan for nursing homes that participate in the Medicaid program and to present a bill to the 102nd General Assembly to implement the plan. Developing quality standards and providing additional reimbursements to nursing homes meeting or exceeding such standards were key provisions of the resolution. The Commissioner has asked various parties to serve on a committee to develop the plan.⁵

⁵ Senate Joint Resolution 667, 101st Tennessee General Assembly.

Objectives

In addition, a subcommittee of the House Human Resources Committee, chaired by Representative John Arriola, heard testimony about the state of nursing homes in Tennessee and requested that the Office of the Comptroller prepare a report reviewing the adequacy and enforcement of existing nursing home quality of care standards and related issues involving Medicaid payment for nursing home facilities. (See Appendix 1.) The objectives of this study are to examine the regulatory process, Tennessee's reimbursement methodology, staffing issues, abuse and neglect, and other matters affecting nursing homes and their residents.

Methodology

This report attempts to review and analyze the organizational structure of the various governmental systems that affect nursing homes in Tennessee. The report does not offer conclusions regarding individual nursing facilities. The conclusions reached and recommendations made in this report are based on the following:

- Interviews with federal and state officials, including the Health Care Financing Administration, the Division of Health Care Facilities within the Tennessee Department of Health, the Commission on Aging, the Tennessee Department of Finance and Administration, the Tennessee Department of Health, and the Tennessee Bureau of Investigation;
- Interviews with industry representatives, including the Tennessee Health Care Association (THCA), National Health Care (NHC), and the Tennessee Association of Homes and Services for the Aging;
- Interviews with advocates for quality care for nursing home residents, including the AARP and the Tennessee Justice Center;
- Interviews with officials in other states;
- Review of state statutes and other documents such as annual reports, audits, planning documents, and regulations;
- Review of federal statutes, regulations, and reports;
- Review of newspapers and professional journals and magazines;
- Review of data provided by the Division of Health Care Facilities, the Division of Long-Term Care, the Commission on Aging, and the Tennessee Bureau of Investigation; and
- Observation of a nursing home survey.

Involved Agencies and Organizations

The following list of state agencies, federal agencies, advocacy organizations and interest groups illustrates the size and complexity of the structure of nursing home service delivery. The involvement of some of these agencies is limited to specific activities, and has come about in response to specific problems. Some administer federal programs such as the Tennessee Commission on Aging, which administers the Older Americans Act. Other agencies' involvement is more comprehensive such as the Division of Health Care Facilities, which is responsible for surveying nursing facilities. Jurisdiction overlaps

among some agencies. For example, the Division of Health Care Facilities, Adult Protective Services, local law enforcement, and the Tennessee Bureau of Investigation may all be involved in investigating abuse and neglect cases. Whether their involvement is limited or comprehensive, all of these agencies have a direct effect upon the delivery of nursing home services in Tennessee.

State Agencies

- Department of Health, Division of Health Care Facilities Services [TCA Title 68, Chapter 11]–The agency empowered to license and regulate hospitals, recuperation centers, nursing homes, homes for the aged, residential HIV support living facilities, assisted-care living facilities, home care organizations, residential hospices, birthing centers, ambulatory surgical treatment centers and facilities operated for the provision of alcohol and drug prevention and/or treatment services; also known as the state survey agency, the Division is under contract with the Health Care Financing Administration to inspect nursing homes that receive Medicare or Medicaid funds.
- Department of Health, Board for Licensing Health Care Facilities [TCA Title 68, Chapter 11]–The entity appointed by the Governor to adopt fire and life safety code regulations applicable to the facilities listed above.
- Health Facilities Commission [TCA Title 68, Chapter 11]– The agency established to administer the Certificate of Need Program for the establishment or modification of new health care institutions, facilities, or covered services to determine the necessity of new health care resources in the area to be served.
- Department of Human Services, Adult Protective Services [TCA Title 71, Chapter 6]– The agency with responsibility to protect vulnerable adults from abuse, neglect, or exploitation.
- Tennessee Bureau of Investigation, Medicaid Fraud Unit [TCA Title 38, Chapter 6]– The entity responsible for conducting criminal investigations in the areas of Medicaid/TennCare and Medicare provider fraud and patient abuse/neglect in facilities participating in the federal medical assistance program.
- Commission on Aging [TCA Title 71, Chapter 2]– The agency administering the federal Older Americans Act in Tennessee, a component of which is the Long-term Care Ombudsman Program established to protect the rights of long-term care facility residents, resolve complaints and improve their quality of life.
- Department of Finance and Administration, TennCare Division of Long Term Care – The administrative entity responsible for determining patients’ medical eligibility for Medicaid payment, for administering Medicaid payments for long-term care, and for making final determinations on sanctions recommended by the Division of Health Care Facilities for Medicaid-only nursing homes.
- Department of Finance and Administration, Office of Investigations – The office that investigates allegations of wrongdoing by state employees, including state surveyors.
- Comptroller of the Treasury, Medicaid/TennCare Section, Division of State Audit – The office that is responsible for audit and rate-setting for nursing facilities participating in the TennCare program.

Federal Agencies

- Department of Health and Human Services, Health Care Financing Administration (HCFA) – The agency that oversees the Medicare and Medicaid health care financial assistance programs for elderly, disabled, or low-income persons.
- Government Accounting Office (GAO) – The Congressional auditing agency.
- Department of Justice – The agency investigating civil rights violations alleged to occur in nursing homes.
- Special Committee on Aging – A U.S. Senate committee established to study matters pertaining to older people, including maintaining health, assuring adequate income, finding employment, engaging in productive and rewarding activity, securing proper housing, and, when necessary, obtaining care or assistance; the committee has heard extensive testimony related to nursing homes.
- U. S. Attorney’s Office – Legal counsel for the United States with responsibility to prosecute fraud and civil rights cases.

Other Associations and Organizations

- Tennessee Health Care Association (THCA) – A trade organization representing nursing facilities.
- Tennessee Association of Homes and Services for the Aging – An association of facilities and organizations dedicated to providing quality housing, health, community and related services for the elderly; members include skilled nursing facilities, nursing facilities, continuing care retirement communities, assisted care living facilities, homes for the aged, elderly housing, and agencies serving senior adults.
- American Association of Retired Persons (AARP)– A non-profit organization that conducts activities and programs that promote social welfare for midlife and older persons; the Tennessee affiliate recruits volunteer ombudsmen for nursing homes.
- Tennessee Justice Center – A non-profit organization whose mission is to provide free legal representation, advocacy, and counseling for clients in civil cases in the areas of health care and public assistance.

Background

The Social Security Act (*42 U.S.C. 1396r*) establishes federal requirements for nursing home participation in the Medicare and Medicaid programs. The Health Care Reform Act, a part of the Omnibus Budget Reconciliation Act of 1987, authorized the Health Care Financing Administration (HCFA), a division of the U.S. Department of Health and Human Services, to issue certain regulations and program guidance for health care facilities, including nursing homes. HCFA implemented the final enforcement regulations to comply with the Omnibus Budget Reconciliation Act in July 1995.⁶

⁶ HCFA Fact Sheet, September 2000.

HCFA is responsible for determining whether nursing facilities comply with federal regulations and are eligible to participate in the Medicare and Medicaid programs. To fulfill this responsibility HCFA contracts with state survey agencies to certify nursing homes. These agencies determine certification recommendations through annual surveys and complaint investigations. In Tennessee, the state survey agency is the Department of Health, Division of Health Care Facilities. The Division also provides administrative support to the Board for Licensing Health Care Facilities, and licenses and inspects nursing homes annually to determine compliance with state rules and regulations. According to the Assistant Commissioner of Health Licensure and Regulation, on May 18, 353 nursing homes in Tennessee participated in the Medicare and Medicaid programs and were subject to both federal and state requirements. Six nursing homes served only privately paying residents and were governed only by state licensing regulations.

In addition to nursing homes, the Division of Health Care Facilities also licenses and regulates hospitals, recuperation centers, homes for the aged, residential HIV supportive living facilities, assisted-care living facilities, home care organizations, residential hospices, birthing centers, ambulatory surgical treatment centers, and facilities operated for the provision of alcohol and drug prevention and/or treatment services.⁷

The Division of Health Care Facilities' budget for FY2000-01 is \$9,488,300. Federal funds account for \$4,453,900, state funds appropriated are \$3,757,000 and \$1,277,400 comes from other sources.⁸

Federal Enforcement Efforts

Because of nationwide concern about conditions in nursing homes, the U.S. Senate Special Committee on Aging has held a series of hearings in recent years dealing with a variety of nursing homes issues, ranging from staffing to the increased number of bankruptcies to states' enforcement activities. HCFA has responded to Congressional dismay by placing additional requirements on both state survey agencies and nursing homes in an effort to ensure quality care. One example is the State Agency Quality Improvement Program (SAQUIP), announced in 1996, requiring state survey agencies to report to HCFA annually on whether a state complies with specific standards.⁹

Furthermore, in 1998 HCFA announced a major Nursing Home Initiative to improve the quality of care Medicare and Medicaid beneficiaries receive in nursing homes. The Initiative remains an evolving process with new mandates introduced periodically.

As part of this Initiative, the federal government pledged to work with states to improve inspections, to crack down on nursing homes that repeatedly violate safety rules, to require nursing homes to conduct criminal background checks on all new employees, to reduce the incidence of bedsores, dehydration, and malnutrition, and to publish nursing home quality ratings on the Internet. HCFA also announced its intention to strengthen its oversight of state inspections by targeting states with weak inspection systems.¹⁰

⁷ *Tennessee Code Annotated* §68-11-202(a)(1).

⁸ Tennessee State Budget, Page B-149.

⁹ United States Government Accounting Office, Report to the Special Committee on Aging, U. S. Senate, GAO/HEHS-00-6, *Nursing Home Care: Enhanced HCFA Oversight of State Programs Would Better Ensure Quality*, November 1999.

¹⁰ Statement of Michael Hash, Deputy Administrator, Health Care Financing Administration, to the Senate Special Committee on Aging, July 28, 1998.

However, on-going federal monitoring showed that many nursing homes continued to violate rules and that states' enforcement was sometimes too lenient. In 1999 HCFA announced additional new steps to ensure high quality care in nursing homes, including tougher fines, instructing states to investigate complaints involving harm to residents more quickly, launching a national campaign to prevent abuse and neglect, and promoting the Nursing Home Compare web site for families to obtain comparative information about each nursing home.¹¹ See Appendix 6 for the chronology of HCFA's steps to implement the Initiative.

¹¹ Health Care Financing Administration News Release, March 16, 1999.

Analysis and Conclusions

Inspection/Investigation Practices

The percentage of nursing homes in Tennessee with serious deficiencies increased from 11.1 percent to 24.1 percent after implementation of the Nursing Home Initiative. However, the reason for the increase is not clear. Some interviewees believe that HCFA, through the Nursing Home Initiative, increased pressure on states (including Tennessee) with low percentages to write more deficiencies to make their statistics more comparable to the remainder of the country. Others assert that the new survey tools, such as revised protocols and better surveyor training, help the state to identify more violations of standards. At least one interviewee expressed the belief that the initial low percentages of deficiencies resulted from improper surveyor/industry relationships.

Nursing home representatives believe that political pressure is behind the more scrupulous oversight and question whether the number of deficiencies reflects quality of care. One spokesman estimated that civil penalties amounting to \$300,000 were imposed in 1998, increasing to \$3.6 million in 1999. He questions, "Were we that much worse in 1999 than we were in 1998?"

The industry is apprehensive about the financial impact of the penalties and consequential negative publicity arising from the enhanced enforcement. Some facilities cannot afford to pay the substantial penalties (in some cases as high as \$500,000) and such penalties would force them to go out of business. The vast majority of heavy penalties are under appeal. Additionally, nursing homes are suffering damaged reputations which might lead to fewer admissions and decreased revenues.

Industry members also criticize the inconsistent and inequitable application of standards to all nursing homes. They contend that even though HCFA provides guidelines for surveyors to follow, the application of standards is subject to an individual surveyor's interpretation. One administrator admonished that isolated incidents can be blown out of proportion and that many of the regulations are "nit-picky."

In a progress report on the Nursing Home Initiative to Congress, the Government Accounting Office found wide variation across states in the share of homes cited for actual harm and immediate jeopardy deficiencies. Exhibit 4 presents the percentage of homes with actual harm and immediate jeopardy deficiencies before and after implementation of the Nursing Home Initiative.

Twenty-seven states increased the number of serious deficiencies cited, while 11 states showed decreases. Before the Initiative, Tennessee had the third lowest percentage of homes with serious deficiencies at 11.1 percent. Tennessee's percentage was significantly lower than the national average of 27.7 percent. After the initiative, the percentage of homes with serious deficiencies rose to 24.1 percent, making Tennessee the 11th lowest state. (See Exhibit 4.) Tennessee's percentage is now slightly lower than the national average of 29.5 percent. Only Arizona, Arkansas, and New York showed larger differences than Tennessee before and after the Initiative.

The number of deficiencies written on individual homes in the state in the last year ranges from 0-26. The average number of deficiencies per home in Tennessee is six, more than the national average of five.¹²

Exhibit 4

State Percentages of Homes Cited for Deficiencies *			
State	# Homes Surveyed 1/99-7/00	Before Initiative 1/97-7/98	After Initiatives 1/99-7/00
Maine	124	7.4	10.5
Wisconsin	424	17.1	14.6
Oklahoma	394	8.4	15.0
Colorado	229	11.1	16.6
Virginia	282	24.7	19.5
West Virginia	144	12.3	20.1
Louisiana	365	12.7	20.3
Florida	746	36.3	21.7
Iowa	428	39.2	22.7
New Jersey	336	13.0	23.8
Tennessee	353	(Rank #3) 11.1	(Rank #11) 24.1
Maryland	188	19.0	24.5
Texas	1313	22.2	24.9
Georgia	364	17.8	25.0
Kentucky	306	28.6	25.2
Missouri	565	21.0	25.7
Nebraska	241	32.3	26.6
New York	606	13.3	27.6
California	1301	28.2	28.2
Ohio	995	31.2	28.6
Nation	16854	27.7	29.5
South Carolina	176	28.6	29.5
South Dakota	112	40.3	29.5
Pennsylvania	774	29.3	30.7
Arkansas	253	14.7	30.8
Illinois	891	29.8	31.1
Mississippi	196	24.8	31.6
Minnesota	437	29.6	32.5
Massachusetts	541	24.0	32.9
Arizona	125	17.2	36.8
Kansas	404	47.0	36.9
Montana	105	38.7	39.0
Alabama	225	51.1	41.3
North Carolina	409	31.0	42.1
Michigan	442	43.7	45.9
Indiana	581	40.5	48.2
Oregon	157	43.9	53.5
Connecticut	260	52.9	53.5
Washington	281	63.2	57.7

Source: Testimony of William Scanlon, Director of Health Care Planning and Public Health Issues, Government Accounting Office, to Senate Special Committee on Aging, September 28, 2000.

*The GAO excluded 12 states and the District of Columbia because they had fewer than 100 homes surveyed since January 1999.

¹² Nursing Home Compare web site found at <http://www.hcfa.gov>. Last updated on November 29, 2000.

According to interviewees for this study and a report from the Government Accounting Office, nursing home officials can generally predict when surveys will be conducted. As a result, facilities can present themselves in ways during inspections that do not reflect their normal routines and practices.

In an attempt to reduce predictability, since January 1, 1999, HCFA has required states to begin at least 10 percent of standard surveys outside normal workday hours; i.e., early morning, evening, or weekend hours. HCFA also encourages states to avoid scheduling a home's survey for the same month as the one in which the home's previous survey was conducted.

States must conduct annual surveys of each nursing home on average every 12 months and no less than every 15 months. Although HCFA allowed a period of up to 15 months between surveys, Tennessee statutes required licensure inspections within 12 months until the General Assembly passed legislation in the 2000 session to make the state's requirement consistent with the federal regulation.¹³ However, despite this flexibility, nursing home personnel indicated to Comptroller's staff that they still are able to predict the survey within three weeks and prepare for it. In fact, one national chain's representatives told Comptroller's staff that the corporate office sends a mock survey team into the facility within 90 days of the expected survey to help prepare them for the annual visit.

Government Accounting Office staff looked at the predictability of surveys in six states; four (California, Missouri, Washington, and Tennessee) were visited on site and two others, Maryland and Michigan, which had previously been assessed, were interviewed. The report found that in Tennessee over half the surveys were conducted within 15 days of the anniversary of the previous routine survey. Of the six states involved in the study, Tennessee had the highest rate of predictability, as illustrated in Exhibit 5.

Exhibit 5

State Comparison of Predictability					
State	# of Homes	% Surveyed within 1 yr. 15 days of previous survey	% Surveyed within 14-15 months of previous survey	% Surveyed within 15-16 months of previous survey	Total % of surveys considered predictable
Tennessee	351	56.1	0	0	56.1
California	1,301	8.0	31.4	15.0	54.4
Michigan	434	14.0	14.3	9.9	38.2
Missouri	476	11.1	13.9	8.8	33.8
Washington	278	15.1	17.6	1.0	33.7
Maryland	243	4.9	14.8	9.0	28.7

Source: Testimony of William Scanlon, Director of Health Care Planning and Public Health Issues, Government Accounting Office, to Senate Special Committee on Aging, September 28, 2000.

¹³ Interview with Katy Gammon, Director of Health Care Facilities, Tennessee Department of Health, June 6, 2000.

In its testimony to the Senate Committee on Aging the GAO suggested that the predictability problem could be mitigated by segmenting the surveys into more than one visit.¹⁴

State investigators with the Department of Finance and Administration's Office of Investigations have probed into accusations that state surveyors tipped off nursing homes when surveys were imminent. The unit has conducted five investigations of alleged bribery of surveyors or of giving notice to nursing homes before surveys during the last five years; however, the unit has not substantiated any of the allegations. The Office conducted its last investigation of this type two years ago. Staff told Comptroller's staff that they suspect more instances of surveyor wrongdoing than are reported to the unit.¹⁵

The Division of Health Care Facilities does not always comply with federal timeframes for investigating complaints against nursing facilities, possibly endangering residents. Performance audits of the Board for Licensing Health Care Facilities in 1996 and 1998 found that abuse and neglect complaint investigations need to be improved. The Division of Health Care Facilities did not always investigate in a timely manner. Complaint logs did not always contain complete information. Departmental policy required surveyors to investigate complaints as follows:

- Priority 1 (possibly constituting immediate jeopardy) within two days,
- Priority 2 (involving situations that have been controlled by the facility and have resulted in less serious harm) within 60 days, and
- Priority 3 (those not detrimental to the patients or their care) at the discretion of the regional administrator or during the next annual survey.¹⁶

In March 1999, HCFA issued new regulations mandating that complaints be investigated within shorter time frames. Surveyors must respond to reports alleging immediate jeopardy within two days; they have 10 days in which to investigate all other complaints alleging actual harm. The Government Accounting Office recently requested data from the Division to determine the extent to which Tennessee complies with this new federal requirement. According to a September 2000 GAO report based on that data, during the last six months of 1999, Tennessee was able to investigate only about 25 percent of its actual harm complaints within 10 days. Washington State, on the other hand, was able to investigate about 76 percent.

The Division of Health Care Facilities employs 79 staff to conduct annual surveys and to investigate complaints and unusual incidents in Tennessee's 359 nursing homes. Six positions were vacant as of October 11, 2000. According to department officials, Division management is experiencing considerable difficulty in recruiting and retaining survey staff, particularly registered nurses. Division officials cite low pay and job difficulty as major reasons for high turnover. Department of Health staff is attempting to remedy this situation by reclassifying team leaders from positions of Public Health Nurse Consultant 1's to PHNC 2's. Additionally, in 2000, the General Assembly appropriated funds to create nine new survey positions. In early January, the Department of Personnel

¹⁴ Web site: GAO/T-HEHS-00-209, p. 5.

¹⁵ Interview with Dalton Davis, Assistant Director of Audit and Investigations, Office of Investigations, Tennessee Department of Finance and Administration, August 3, 2000.

¹⁶ Performance Audit: Board for Licensing Health Care Facilities, p. 13, July 1996.

approved the positions and Division management is working to fill them. Additionally, the Division is asking for an additional nine positions as an improvement in the FY2001-2002 budget.¹⁷

In some states, the increased HCFA emphasis has resulted in changes in procedures. For example, some states have increased the number of surveyors. Some have dedicated staff to conduct complaint investigations, and some states have instituted organizational changes. Tennessee and at least one other state require that a licensed nurse determine the seriousness of offenses. In spite of such positive results, the report found that central oversight by state survey management continues to be needed because of uncertainty about whether complaints are properly classified.

The GAO report further revealed that Tennessee received only about half as many complaints as Missouri and Washington, which have toll-free complaint lines. Maryland has seen a 250 percent increase in the number of its complaints since starting a toll-free number.

HCFA plans to issue more guidance to the states in 2001. The new procedures will:

- Identify a complaint investigation process that all states could implement,
- Establish elements of a national reporting system,
- Identify methods for HCFA to monitor state complaint investigation processes, and
- Identify model programs or practices that make complaint investigations more effective and prevent abuse and neglect.¹⁸

A relatively few number of facilities account for the majority of complaints.

According to 1999-2000 complaint data provided by the department, approximately 16 percent of facilities accounted for approximately 50 percent of complaints/unusual incidents.¹⁹ With proper care in recording and analysis, the complaint database could assist the department in focusing its resources on those facilities with operating policies and/or procedures that lead to high numbers of complaints. The number of complaints recorded is not in and of itself an indicator of the quality of service of a nursing facility. The number of substantiated, or “founded,” complaints, along with an analysis of the scope and severity of each deficiency would be such an indicator.

Staff review of complaint data leads to findings similar to previous performance audits. Because of a significant number of empty fields in the database, Comptroller’s staff did not attempt to calculate the percentage of timely responses. However, staff concluded that either the department did not respond to complaints in a timely manner, or the department did not conscientiously record data during the database time period.

¹⁷ E-mail correspondence from Assistant Commissioner Judy Eads, Department of Health, February 13, 2001.

¹⁸ United States Government Accounting Office, Report to Congressional Requestors, *Nursing Homes: Sustained Efforts Are Essential to Realize Potential of the Quality Initiative*, September 2000.

¹⁹ Data was provided by the department. The database contained records from September 13, 1999, to September 6, 2000. Before analysis, 6 records were deleted because of missing or ambiguous date fields.

A summary analysis of complaint data revealed:

- **16 percent** of facilities accounted for **50 percent** of complaints/unusual incidents.
- There were **1487** complaints/unusual incidents recorded.
- These were registered against **278** different facilities (of 353 operating).
- The **median** number of complaints/unusual incidents was **four** (i.e., there were an equal number of facilities with more than four and fewer than four complaints).

Allegations that nursing homes hide unusual incidents may be unfounded. Some persons appearing before the Human Resources Subcommittee of the House Health and Human Resources Committee during the 2000 session testified that some nursing homes do not report unusual incidents as required. Additionally, some interviewees shared the same belief with Comptroller's staff. It is difficult to tell if facilities fail to report all significant incidents. However, Division of Health Care Facilities staff and nursing home representatives both agreed that nursing homes tend to err on the side of caution, sometimes reporting incidents that are not significant. The Division is developing guidelines to help facilities decide when to report unusual incidents.

Deficiency Correction

Although HCFA has federal oversight responsibilities for nursing facilities, responsibility for correcting deficiencies in substandard facilities lies with the state.

Unless the Division of Health Care Facilities focuses more on post-survey activities, patterns of substandard care may continue within the protocols established by HCFA. Nothing prohibits state officials from developing and implementing supplemental enforcement mechanisms that focus on correcting deficiencies. Although state surveyors write deficiencies, make civil monetary penalty recommendations, require plans of correction, and conduct follow-up visits as required by HCFA, nursing home residents may still receive substandard care.

As part of the overall design of the nursing home payment and certification system, oversight is a shared federal and state responsibility. In actual practice, however, the degrees of involvement of the two levels of government in the nursing home system are significantly different. HCFA is concerned primarily with administering the payment system by which nursing homes are reimbursed, and secondarily with developing a monitoring system for ensuring that the federal money in that reimbursement is appropriately spent. States must implement HCFA's monitoring system, and HCFA places significant blame for nursing facility problems on the state survey agencies, citing the states' "failure...to investigate complaints," the states' weak efforts "to address levels of quality in 'special focus' facilities," the "failure...of states to conduct [timely] surveys," and the predictability of "state-run nursing home inspections."²⁰

²⁰ Testimony: Michael Hash to the Senate Committee on Aging
(<http://www.senate.gov/~aging/hr61mh.htm>, p. 1-2).

HCFA stipulates specific procedures, called protocols, for surveyors to use when inspecting facilities and investigating complaints and unusual incidents. Violations of standards of care are called deficiencies and are categorized by “tag” numbers. Deficiencies are classified according to the scope and severity grid in Exhibit 6. Scope refers to the number of residents potentially or actually harmed; severity is the potential for or occurrence of harm to residents. Scope and severity codes help determine the corrections nursing homes must undertake and also help determine the sanctions surveyors recommend.

HCFA requires states to follow up promptly on all serious deficiencies. The facility must submit a plan of correction and the Division must re-survey the facility within 90 days or the facility will be denied payments for new Medicare and Medicaid patient admissions. If the nursing home has not corrected the deficiency, it is cited again and subject to more severe sanctions.

The decision-making process prescribed by HCFA to determine proper scope and severity levels is found in Appendix 8.

HCFA makes final decisions for enforcement actions involving homes with Medicare certification – about 86 percent of all homes. States make final decisions for enforcing standards in homes with Medicaid-only certification. Federal enforcement actions can involve, among other sanctions, corrective action plans, monetary fines, denying the home Medicare and Medicaid payments until corrections are made and terminating participation in the programs. HCFA considers recommendations from states when making final determinations on sanctions, but may change the final outcomes. States may also use state licensure authority to impose sanctions.²¹

As part of a review of HCFA, the Government Accounting Office presented a progress report to the Senate Special Committee on Aging on September 28, 2000. The report focused on the quality and predictability of state surveys. The GAO had reported in earlier studies that state surveyors often missed significant care problems, especially pressure sores, malnutrition, and dehydration, due to the resident sampling methods they used. As part of the Initiative, surveyors began using Minimum Data Set information to select samples via quality indicators that flag the prevalence of care problems. HCFA also developed a set of new investigative procedures for surveyors to follow that was intended to make facility inspections more thorough and more uniform. Moreover, HCFA is still developing new protocols that will not be introduced until 2002 or 2003.

²¹ Interview with Dorothy Elder, Director of Certification, and Jere Younger, SAQUIP Coordinator, Division of Health Care Facilities, Tennessee Department of Health, July 28, 2000.

Exhibit 6

Federal Deficiency Scope & Severity Grid

Severity	Scope		
	Isolated	Pattern	Widespread
Immediate jeopardy to resident health or safety	Plan of Correction Required - Category 3 Optional - Category 1 Optional - Category 2	Plan of Correction Required - Category 3 Optional - Category 1 Optional - Category 2	Plan of Correction Required - Category 3 Optional - Category 2 Optional - Category 1
Actual harm that is not immediate jeopardy	Plan of Correction Required - Category 2 Optional - Category 1	Plan of Correction Required - Category 2 Optional - Category 1	Plan of Correction Required - Category 2 Optional - Category 1 Optional - Temporary Management
No actual harm with potential for more than minimal harm that is not immediate jeopardy	Plan of Correction Required - Category 1 Optional - Category 2	Plan of Correction Required - Category 1 Optional - Category 2	Plan of Correction Required - Category 2 Optional - Category 1
No actual harm with potential for minimal harm	No Plan of Correction, No remedies, Commitment to Correct	Plan of Correction	Plan of Correction

Scope and severity level constitutes substandard quality of care.

Deficiencies in these scope and severity levels do not indicate a facility is out of substantial compliance with standards.

Category 1

Directed Plan of Correction
State Monitoring**; and/or
Directed In-Service Training

Category 3

Temporary Management
Termination (may be imposed by the state or HCFA at any appropriate time)
Optional CMP from \$3,050 to \$10,000 per day of deficiency

Category 2

Denial of Payment for New Admissions*;
Denial of Payment for All Individuals**; and/or
Civil Monetary Penalties (CMPs) from \$50 to \$3,000 per day of deficiency

* Must be imposed when a facility is not in substantial compliance within three months after being found out of compliance.

** Must be imposed when a facility has been found to have provided substandard quality of care on three consecutive standard surveys.

Source: Created from HCFA grid; annotated by Comptroller staff.

The GAO report concluded that many of the activities begun under the 1998 Initiative need continued federal and state attention; however, the report acknowledged that because HCFA is phasing in the implementation of the Initiative, many states, including Tennessee, are in transition. The study showed a marginal increase nationwide in the number of homes with documented actual harm or immediate jeopardy deficiencies; however, what is not known is whether the increase can be attributed to increasingly poor care or to more vigorous identification and classification of deficiencies.

Michael Hash (HCFA Deputy Administrator) indicated in his testimony that HCFA has measured the success of the Nursing Home Initiative by the states' compliance with the 1998 policy changes. Hash listed the following "key successes" of the initiative: a "substantial increase in the number of surveys"; "more citations...for substandard care"; the referral of facilities for "immediate sanctions"; continued withholding of Medicare-Medicaid funds from problem facilities until "necessary corrections" have been made; and positive public response to an information web site.²²

Although it may be a necessary first step toward improving the survey process (and thus fulfilling HCFA's oversight role), an increase in the number of citations for substandard care is not a measure of success, nor is a statistical "smoothing" of the number and type of deficiency citations among states. HCFA's insistence upon state-to-state statistical uniformity in deficiency citations is based upon the assumption that all states experience the same type of problems and that all problems will be revealed by the types of deficiencies HCFA has defined. However, this attention to identifying deficiencies does not, in and of itself, improve the quality of care or quality of life of nursing home residents, **unless the deficiencies are corrected.** Clearly, measured from the perspective of a nursing home resident, a state's compliance with any policy should not be considered a success unless that policy results in the immediate correction of deficiencies that contribute to substandard care. Such is not the case currently, since the referral for "immediate sanctions" is also an intermediate step toward the correction of deficiencies.

Whether HCFA is correct in blaming states for the failures is once again not likely to be a significant issue for the residents of nursing facilities in Tennessee. And whether HCFA policy changes result in quality of care improvement should become evident in the next several years. The immediate responsibility for improving the quality of care of nursing home residents, however, lies with the states.

The corrective component of the survey process, which involves the preparation and approval of a plan of correction, is often ineffective. The annual survey of nursing facilities is the primary tool HCFA and state agencies use to ensure quality of care for residents. However, the survey serves, for the most part, as an enforcement tool for HCFA rather than as a mechanism to correct deficiencies.

²² Testimony of William Scanlon, Director, Health Care Planning and Public Health Issues, Government Accounting Office and Michael Hash (Deputy Administrator, Health Care Financing Administration). September 28, 2000. Document: GAO/T-HEHS-00-209, p. 2.

The automatic imposition of a substantial monetary sanction, based on a surveyor's citing of a deficiency, contributes to the adversarial character of the relationship between surveyors and nursing facility administration. Moreover, the correction of the deficiency often becomes less important to the nursing facility than defending itself, via the appeals process, against the monetary sanction. The survey teams represent a significant gathering of expertise in the field of nursing facility operation. In part because of pressure from HCFA, however, that expertise is employed primarily in citing events and situations that do not comply with HCFA guidelines. It is only rarely, and then only tangentially, employed in processes that lead to the immediate correction of deficiencies. Although plans of correction are required for deficiencies, they are often *pro forma*, and may not be evaluated for implementation or effectiveness until a follow-up survey, or in some cases, the next annual survey is conducted.

In brief, the survey process works from the "top down." It generally satisfies HCFA's plan to improve conditions in nursing facilities over the long term by relying upon punitive actions as deterrents to substandard care. Indeed, HCFA continues to pursue a policy of citation and punishment. The GAO notes that HCFA increased funds in fiscal years 1999 and 2000 "...to hire more federal staff to reduce the large number of pending appeals by nursing homes and collect assessed fines faster. The expectation is that the more expeditious resolution of appeals will heighten the deterrent effect of civil fines."²³

However, the citation process in the past, rather than having been the first step toward correcting deficiencies, has been a first step toward dispute resolution, fine assessment, appeals, fine negotiation, and collection.

The lack of frequent presence by state officials in nursing homes results in sporadic enforcement of standards. Time limitations and the low number of staff reduce the efficiency and effectiveness of survey teams. Survey teams could be assisted by "facility monitors" who would be responsible for visiting nursing facilities for spot checks of conditions and would alert surveyors when conditions warranted a more thorough inspection.

The department currently has authority under TCA §68-11-221 to appoint special monitors for individual facilities that are under a suspension of admissions. The department also has discretion to appoint monitors for any facility with deficiencies that are "detrimental to the direct care of the patients."

Facility administrators and industry representatives have noted that the survey process is disruptive, even for well-managed facilities with good survey records. While facility monitors would not replace survey teams, they could observe conditions and operations of facilities to provide preliminary information, helping the team focus quickly on potential problem areas during the regular survey. In those facilities with records of deficiency citations or a substantial number of complaints, the facility monitor could remain on-site until corrections are made. In such instances, the cost of the facility monitor could be borne in part by the facility.

²³ Testimony of William Scanlon, Director, Health Care Planning and Public Health Issues, Government Accounting Office. Document: GAO/T-HEHS-00-209, p. 10.

Facility monitor reports would also allow the Division of Health Care Facilities to focus on problem facilities. The General Assembly has increased the time period between surveys from 12 to 15 months, the maximum allowable by HCFA. Information provided by facility monitors could allow the Division to extend the time between surveys for well-run facilities and reduce the time between surveys for those facilities with identified problems.

Although the shortage of qualified personnel to fill surveyor positions is a recognized fact, there should be restrictions against the department using personnel in facility monitor positions as regular surveyors. The benefit of monitors would derive from their mobility and the unpredictability of their visits and would be reduced if monitors were engaged in the regular survey schedule.

Federal and state monetary penalties do not encourage immediate correction of deficiencies nor do they lead to long-lasting changes. This punitive approach to enforcement often results in the diversion of significant facility and government resources from activities that could improve the quality of care.

Both federal and state law allow the Division of Health Care Facilities to recommend civil monetary penalties as sanctions against deficient nursing homes. Congress first enacted civil monetary penalties in 1981 and has since increased the number and types of circumstances under which they may be imposed. However, HCFA did not rigorously enforce standards and require penalties until 1995. The Tennessee General Assembly first enacted state monetary penalties in 1987 (TCA §68-11-801 et.seq.), discontinued them in 1995, and reinstated them in 1998.²⁴

Civil monetary penalties are indirect approaches to deficiency correction. The theory behind this sanction is that nursing facilities will provide quality care to avoid the penalties. In practice, however, only when the deterrent effect is significant, and when nursing facilities subscribe to its enforceability, will the nursing facility residents benefit by receiving care that meets the standards established by HCFA.

Federal regulations allow a state with a unique enforcement sanction to obtain HCFA approval to use it in lieu of a federal sanction. The state must satisfy HCFA that its sanction is as effective as a federal remedy in deterring noncompliance and correcting deficiencies.²⁵ This option in HCFA's enforcement strategy provides an opportunity for states to emphasize the correction of deficiencies, rather than to subscribe to the traditional sanction of imposing fines. Tennessee uses no alternative enforcement mechanisms.

Federal Penalties

Final decisions for imposing federal civil monetary penalties are not made by the Division of Health Care Facilities, but rather by HCFA or the Division of Long-Term Care within the Bureau of TennCare, depending on the type of facility being cited.

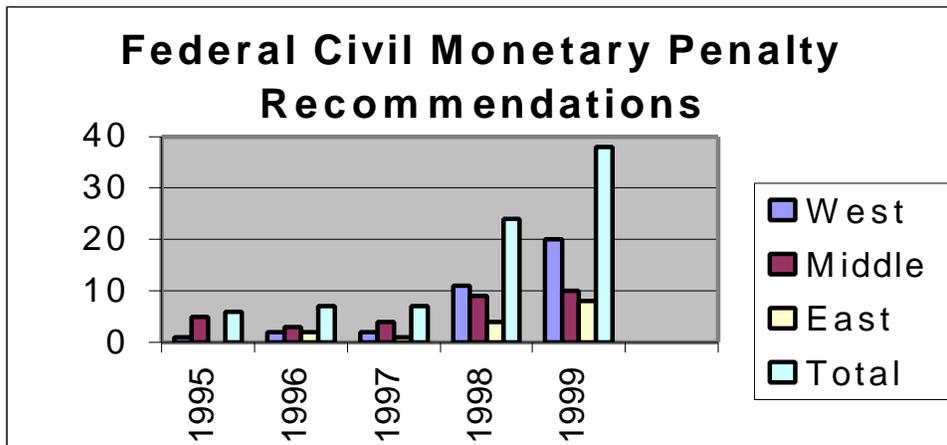
²⁴ Interview with Dorothy Elder, Director of Certification, and Jere Younger, SAQUIP Coordinator, Division of Health Care Facilities, Tennessee Department of Health, July 28, 2000.

²⁵ United States Government Accounting Office, Report to Congressional Requestors, *Nursing Homes: Sustained Efforts Are Essential to Realize Potential of the Quality Initiative*, September 2000.

When skilled nursing facilities (Medicare-only homes) and dually certified facilities (homes participating in both Medicare and Medicaid programs) are cited for serious deficiencies, the Division of Health Care Facilities recommends federal sanctions to HCFA after an internal review process. The Scope and Severity Grid in Exhibit 6 explains how recommendations are chosen. HCFA reviews all documents related to the survey to confirm or modify the suggested sanctions. HCFA notifies the facility and the Division of its decision by letter. Federal policy generally gives nursing homes a grace period of 30 to 60 days to correct the deficiency. If the facility disagrees with HCFA's decision, it may appeal. Because the dollar amounts are usually substantial and because HCFA issues news releases about the sanctions to affected communities, facilities frequently appeal the decisions, which they may do within 60 days of receiving the notification letter from HCFA. If the facility appeals, HCFA does not collect the penalties until after the final administrative decision. If the facility does not appeal, HCFA reduces the penalty amount by 35 percent. HCFA retains all penalty money collected from skilled nursing facilities and shares dual facility penalty money with the state proportionate to the number of beds certified as Medicare and Medicaid.

Under the HCFA contract with TennCare, the Bureau's Division of Long-Term Care conducts the penalty review process for Medicaid-only facilities in the place of HCFA. The procedures are essentially the same as the ones used by HCFA. The state collects all monies from penalties on Medicaid-only facilities.

Exhibit 7



Source: Compiled by Comptroller's staff from data provided by the Division of Health Care Facilities

State Penalties

State civil monetary penalties are divided into three types as follows:

1. Type A penalties apply when the conditions in a nursing home are, or are likely to be, detrimental to the health, safety, or welfare of the patients and the commissioner has accompanied this finding by ordering the nursing home to suspend admission of new patients. The statutory assessment is between \$1,500 and \$5,000.
2. Type B penalties directly impact the care of patients and carry a civil monetary penalty of \$500 to \$1,000.
3. Type C penalties apply to violations that are neither directly detrimental to the patients nor directly impact their care. The penalty of \$250 is imposed when nursing homes fail to correct a violation or whenever a violation is repeated within 12 months of the finding of the first violation.

The assessment is doubled if a second civil penalty is imposed for the same violation within 12 months of the first penalty. If a nursing home with a Type A penalty decides to contest both the penalty and the suspension of admissions, an administrative law judge will conduct a hearing. The panel on health care facilities penalties conducts appeal hearings for all other state civil monetary penalties.²⁶

Numerous interviewees told Comptroller's staff that most facilities pay the state penalties because the dollar amounts are insignificant. A review of the Division's 2000 state penalty log shows that between January 1 through August 28:

- the state imposed civil monetary penalties 41 times
- six penalties were for Type B infractions, 34 were Type C, and one was both Type B and C
- a total of \$21,300 had been assessed and \$16,050 collected, with only seven facilities not paying by August 28, 2000.

In 1999:

- 20 facilities were assessed \$9,800, with the state collecting \$8,300
- only one facility penalized in 1999 did not pay the assessment.

Neither HCFA nor the Division of Long-Term Care conducts appeal hearings in a timely manner, and Division of Health Care Facilities staff indicate that several years may pass before they have knowledge of final decisions.²⁷ As a result, the Division of Health Care Facilities lacks basic management information critical to program planning.

The Division of Health Care Facilities is not involved in the appeals process; therefore, it relies on HCFA or the Division of Long-Term Care to provide information related to the status of the sanctions it recommends.

²⁶ *Tennessee Code Annotated* § 68-11-801 et seq.

²⁷ Interview with Dorothy Elder, Director of Certification, and Jere Younger, SAQUIP Coordinator, Division of Health Care Facilities, Tennessee Department of Health, July 28, 2000.

A review of civil monetary penalty logs maintained by the Division shows several unresolved cases:

- 1995 – one facility has an appeal of \$135,000 pending at HCFA
- 1996 – one facility has an appeal of \$21,807.50 pending at HCFA
- 1997 – one facility is appealing a CMP of \$48,000 to HCFA
- 1998 – seven cases totaling \$852,050 are under appeal to HCFA
- 1999 – 19 cases are under appeal to HCFA
- 2000 (through July 13) – six facilities have appealed to HCFA and the status of the remaining 18 recommendations is unknown

A review of Division of Long-Term Care records shows that of eight cases appealed between January 1, 1995, and the present, seven were requested over one year ago and are still pending. The Division has forwarded these requests to TennCare's General Counsel, which has not scheduled hearings because of other TennCare priorities.

Resident Protection Trust Funds

Tennessee did not spend any funds from its two Resident Protection Trust Funds from fiscal year 1994/95 through fiscal year 1999/2000, indicating that the statutory uses of the funds should be reconsidered. Federal and state dollars collected as civil monetary penalties are deposited in separate resident protection trust fund accounts (*TCA §68-11-827.*) Essentially, federal and state laws require these dollars to be used for the betterment of nursing home residents. However, the amount of money collected for penalties by Tennessee is insufficient to impact the quality of care given to residents under current allowable uses of the funds. The Director of Health Care Facilities told Comptroller's staff that both trust fund accounts in Tennessee are reserved for contracting with an emergency nursing facility administrator in the event a facility closes.

Federal Dollars

Federal civil monetary penalty monies collected by HCFA are shared with the states, proportionate to the number of Medicare and Medicaid beds in use in a non-compliant facility. (See page 22 for information about civil monetary penalties.) USC §488.442(f) requires states to apply these federal penalty dollars to the protection of the health or property of facility residents. The funds can be used only to pay for:

- relocating residents to other facilities,
- the state's costs related to the operation of a facility pending correction of deficiencies or closure, and
- reimbursement of residents for personal funds or property lost at a facility as a result of actions by the facility or its agents.

Annual correspondence from the Commissioner of Health to the Commissioner of Finance and Administration shows the following account activity from 1996 through 1999:

Exhibit 8

Federal Resident Protection Trust Fund Balances				
Year	1995-96	1996-97	1997-98	1998-99
Beginning Balance	\$0	\$15,730.00	\$70,137.40	\$70,137.40
Collections	15,730.00	54,407.40	0	73,259.32
Expenditures	0	0	0	0
Fund Balance	\$15,730.00	70,137.40	\$70,137.40	\$143,396.72

Source: Compiled by Comptroller's Staff from Commissioner of Health Correspondence, 1995/96 – 1998/99

State Dollars

Tennessee Code Annotated §68-11-827 requires the Commissioner of Health to create an account to maintain all state civil monetary penalties in a nursing home resident protection trust fund. The funds may be used to protect residents of nursing homes when noncompliance with rules and regulations threatens the residents' care or property, the nursing homes' continued operation, or the nursing homes' continued participation in the Medicaid program.

Annual correspondence from the Commissioner of Health to the Commissioner of Finance and Administration shows the following account activity from 1996 through 1999:

Exhibit 9

State Resident Protection Trust Fund Balances				
	1995-96	1996-97	1997-98	1998-99
Beginning Balance	\$396,078.57	\$397,378.57	\$397,378.57	\$397,378.57
Collections	1,300	0	0	3,500.00
Expenditures	0	0	0	0
Fund Balance	\$397,378.57	\$397,378.57	\$397,378.57	\$400,878.57

Source: Compiled by Comptroller's Staff from Commissioner of Health Correspondence, 1995/96 – 1998/99

In 1999 the General Assembly authorized the Commissioner to use resident protection trust fund dollars to fund a pilot program implementing the Eden Alternative Grant Assistance Program Act. Dr. William H. Thomas founded the Eden Alternative concept to create better social and physical environments for the aging by eliminating loneliness, hopelessness, and boredom through contact with children, plants, and animals.

This Act provides for annual grants of no more than \$5,000 each to five nursing homes, three assisted-care living facilities and two homes for the aged. A June 6, 2000, news release issued by the Department of Health announced the awarding of \$5,000 grants each to seven nursing homes, one assisted-care living facility, and two residential homes for the aged.

State resident protection trust fund monies could be used to provide grants to hire volunteer coordinators, to establish and maintain visitation programs, or to develop programs involving residents in community activities. The department could receive and consider proposals from community groups or advocacy organizations to provide community presence and participation in nursing facilities. The objective of the grant program would be to bring daily community life into nursing facilities.

Data Management

The Department does not systematically analyze facility data to focus on problem areas throughout the system. Consequently, the resources of the department may not be applied as efficiently as they could be. Simple statistical measures of facility data could help the department focus its resources on identified and potential problem facilities. For example, the type of facility control (e.g., corporate, proprietary, government, etc.), in and of itself, should not affect a facility's ability to provide quality care. However, if, through periodic analysis, the department determines that a certain type of facility ownership is highly correlated with certain types of deficient care, then further departmental investigation would be warranted. Regular analysis could also help the department identify and sanction repeat offenders. Without regular, periodic analysis, however, the department will not be able to identify with reasonable certainty the problem areas to which department resources should be directed. In addition to contributing to administrative efficiency, regular data analysis and reporting would help corroborate or refute much of the anecdotal evidence regarding nursing facilities that confronts the public and the General Assembly.

HCFA provides information systems that states use to collect data related to various aspects of nursing home regulation. These information systems include the On-Line Survey, Certification and Reporting System (OSCAR), the complaint database, and the Minimum Data Set database. In addition, the department maintains licensing information in their own Bureau of Information Resources.

Both the GAO and HCFA acknowledge that the current data system is complex and cumbersome. However, HCFA has begun a gradual implementation of a new data system. HCFA's Data Systems Group estimates that the Quality Improvement and Evaluation System (QIES), which will replace and combine various data systems, including OSCAR and the complaints database, will not be fully implemented until January 2002. Various other components of the system will be implemented during 2001, including databases on long-term care, case mix, minimum data set, scheduling and tracking, and regulation guidelines.

Data analysis should not be postponed, however, until the complete implementation of the new system. The department could conduct standard statistical analysis using the current system and could begin to focus on problem areas identified by such analysis.

The Department's complaint database is incomplete and mixes complaints by individuals and entries of unusual incidents by facilities. Because unusual incidents are not necessarily indicators of poor care, using the data to identify substandard facilities is difficult. Complaint data is maintained in a database provided to Tennessee by HCFA.

Each state regional office maintains its own information and submits data on disk to the central office on a scheduled basis.²⁸

Several problems, either in database design or record maintenance, prevent an accurate analysis of data. These include the following:

- Comparing the number of substantiated complaints [those that upon investigation are found to have merit] with the number of unsubstantiated complaints is difficult. Either a significant number of complaints have not been investigated or results of the investigations have not been recorded.
- Comparing the number of “self-reported” unusual incidents with the number of complaints from other sources is difficult because the source description code in the complaint database aggregates complaints from “Facility Employee/Ex-employee.”
- Analyzing with reasonable precision the deficiencies for which the complaints were filed is also difficult. A significant number of records in the database had no code entered in the “Allegation Type” field. Neither do many of these records have text entered in the “Allegation Description” field. Therefore it is impossible to tell from the complaint database alone whether these complaints were for serious abuse and neglect or for other deficiencies.

Survey teams do not use automated data collection equipment to record and/or substantiate the deficiencies found on annual surveys. Having data collection equipment, including cameras and laptop computers with automated record retrieval capabilities, would enable surveyors to record and substantiate their conclusions more efficiently. Currently, surveyors must use the forms provided by HCFA to record their findings. Automating the forms will help eliminate writing the same information multiple times and should help reduce errors that occur in the transcription process. Moreover, a laptop computer containing other surveyors’ tools, such as protocol and regulation manuals, will ensure ready access to essential references used by surveyors. Additionally, being able to produce immediate photographs of physical evidence can help resolve disputes regarding the scope and severity of cited deficiencies.

²⁸ Interview with Michael Dunn, Director of Health Licensure and Certification Information Systems, Office of Health Licensure and Regulation, Division of Health Care Facilities, Tennessee Department of Health, August 4, 2000.

Nursing Home Staffing

Although Tennessee’s nursing homes generally meet state staffing standards, they do not always employ enough staff to ensure quality of care. According to information in a HCFA report to the Senate Special Committee on Aging, Tennessee’s nursing homes have on average exceeded the minimum state regulations for nursing staff each year since 1996. (See Exhibit 12.) However, Tennessee’s standard is 0.95 hours below the absolute minimum recommended by HCFA in its comprehensive study of nursing home staffing, *Appropriateness of Nurse Staffing Ratios in Nursing Homes*.

The current Tennessee standard of 2.0 hours per patient per day includes time for CNAs, LPNs, and RNs. The following “staffing thresholds” were identified by HCFA as “absolute minimum staffing levels” for direct contact nursing personnel: 2.0 hours for CNAs, 0.75 hours for LPNs or RNs, and 0.2 hours for RNs (a total of 2.95 hours per patient per day). Moreover, the study indicated the CNA threshold was suspect: “We...believe that...2.0 hours of aide time per resident per day will not allow either humane and/or effective care to be implemented.”²⁹ The economic efficiency of CNA staffing levels below 2.0 hours is also suspect, since residents who receive substandard care are more likely to be hospitalized and to require more expensive treatment. HCFA noted that below this level residents experienced “...higher rates of hospitalization for infections and other potentially avoidable causes of hospitalization, higher pressure ulcer incidence rates, and higher rates of significant weight loss.”³⁰

The report also showed that nursing homes in 31 states provided more hours per resident per day than did nursing homes in Tennessee in 1998, the last complete year for which data was available for the report. Tennessee dropped to 36th for the first six months of 1999. (See Exhibit 12.) Nursing staff averages should be interpreted with caution, however, since many factors affect the quality of care nursing staff are able to provide. See the discussion below regarding “minimal” and “optimal” standards.

The language in federal regulations governing staffing in nursing homes is not precise. It requires each facility to “care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident” and “to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care.” More specifically, each facility must use the services of a registered professional nurse for at least eight consecutive hours, seven days a week.³¹ However, most states’ laws or rules are more explicit than these federal minimum requirements. Appendix 5 lists those states, including Tennessee, with more specific regulations.

²⁹ *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes*, Report to Congress, HCFA, <http://www.senate.gov/~aging/hr55hcfa.htm>, p. 2

³⁰ *Ibid*, p. 12-4.

³¹ *U.S.C. § 1819 et seq.* and *U.S.C. § 1919 et seq.*

Tennessee regulations require that nursing homes employ a full-time administrator licensed in Tennessee and a full-time Director of Nursing. They must have at least two nursing personnel, one of whom must be a licensed nurse, on duty at all times. The regulations also require two hours of direct nursing care per patient per day. Of that two hours, 0.4 hour must be provided by licensed nursing personnel.³²

In the past, surveyors have cited facilities for inadequate staff based on the federal standard, even though the facility may have met the state standard. In fact, surveyors have used the federal rather than the state requirement precisely because the federal requirement is not stated in quantitative terms. However, HCFA has clarified its standard: the “current staffing regulations, particularly the general regulation requiring ‘...sufficient nursing staff to attain or maintain the highest practicable...well-being of each resident...,’ are intended to provide appropriate care conceptualized as an **optimal** standard, not a **minimal** standard.”³³ One implication of HCFA’s redefinition of the “highest practicable well-being” standard is that the time standards established by the states are now the only clearly enforceable staffing standards. The issue of definite staffing requirements is further complicated by the fact that in actual practice the Tennessee requirement of 2.0 hours per patient per day may actually have the unintended consequence of reducing the quality of care. Meeting the hourly requirement provides statutory, or *de jure*, evidence that a facility has achieved the state standard of care. However, surveyors are often faced with situations where the actual, or *de facto*, evidence indicates that the care is inadequate.

The GAO has identified 20 states that have enacted legislation to address staffing shortages in nursing homes.³⁴ Some states have addressed the staffing shortage and turnover issues by creating “wage pass-through” programs for nursing facilities. The facilities qualify for increased daily rates based on criteria that generally require the extra money to be directed toward salaries, supplements, benefits or training for licensed nursing staff and certified nursing assistants.³⁵ Accountability measures for most of the programs include cost reporting requirements and/or audit provisions. HCFA has identified other issues related to staffing that might impact quality of care. These include turnover rates, wages and benefits, training, career paths for nurse aides, and management of staffing resources.³⁶

Determining the optimum and/or minimum staffing level and establishing it as a state standard is difficult because the adequacy of staffing levels in a specific facility is determined in great measure by the acuity levels of the facility residents. Because the “case mix”³⁷ within a facility can change daily, the delivery of quality services depends upon a facility’s ability to respond to the different needs of different patient populations.

³² Rules of the Tennessee Department of Health, Chapter 1200-8-6-.04.

³³ *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes*, Report to Congress, HCFA, <http://www.senate.gov/~aging/hr55hcfa.htm>, p. 1-10, emphasis added.

³⁴ GAO/HEHS-00-197, *Nursing Home Quality Initiatives*, p. 53 ff.

³⁵ *Ibid.*

³⁶ *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes*, Report to Congress, HCFA, <http://www.senate.gov/~aging/hr55hcfa.htm>, p. 1-14.

³⁷ “Case mix” is a general term that refers to the various diagnoses of patients. A widely divergent case mix requires a widely divergent service delivery system, which can include many different types of medical and rehabilitative equipment, and personnel with different areas of expertise.

The assessment of service delivery therefore must take into account a number of “facility-specific” variables, which are determined at any given point in time by the patient population. Measuring quality of care as an outcome could be improved by recording the diagnosis and prognosis of patients at admission according to Minimum Data Set standards. This would establish a baseline for analysis of changes in patient condition during residence in specific facilities.

See the following pages for exhibits on resident characteristics and nursing staff averages.

Nursing Home Resident Characteristics

Compared to the rest of the United States, Tennessee has greater percentages of nursing home residents with higher acuity levels needing more staff time and monetary resources to meet their needs. Exhibit 10 compares characteristics of Tennessee’s nursing home residents with those in the remainder of the country.

Exhibit 10

Nursing Home Resident Characteristics		
	% United States	% Tennessee
Residents Who Are Very Dependent in Eating	19	25
Residents Who Are Bedfast	5	10
Residents with Restricted Joint Motion	25	21
Residents with Restraints	9	13
Residents with Pressure Sores	6	8
Residents with Urinary Incontinence	52	55
Residents with Unexplained Weight Gain or Loss	7	9
Residents with Behavioral Symptoms	29	29

Source: www.medicare.gov/NHCompare

Exhibit 11 compares nursing facility staff averages in Tennessee with those in the United States as a whole. The U.S. Full Time Equivalent (FTE) averages have been weighted to allow comparison with Tennessee facilities. HCFA calculates FTEs based on a 35 hour work week.³⁸

Exhibit 11

Comparison of Tennessee Nursing Staff Averages with National Averages					
		Facility Weighted Averages per 35 hour work week			
	Residents/ Facility	RN FTEs	LPN/LVN FTEs	CNA FTEs	Total Nursing FTEs
U.S. Average	80	17.3	18.6	56.9	92.8
Tennessee Average	99	15	19	47	81

Source: compiled by Comptroller's staff from data obtained at www.medicare.gov/NHCompare. Last updated 12/21/00.

Recent Federal Activity to Address Staffing Shortages

The September 2000 Initiative announced by President Clinton to improve the quality of care in nursing homes had several staffing components. Major provisions of the initiative are:

- establishment of a new competitive grant program that would provide \$1 billion over five years to states to improve the quality of care,
- a new requirement that civil monetary penalties be immediately withheld from future payments to nursing facilities (if a nursing home appeals the imposition of the fine and wins the appeal, the government would return the funds with interest),
- a requirement that all nursing facilities participating in Medicaid and Medicare provide HCFA with detailed information on current staffing levels, and
- direction to HCFA to complete its study on staffing ratios within 12 months and to develop and publish federal regulations establishing minimum staffing levels by September 1, 2002.³⁹

³⁸ HCFA provides the following caution when interpreting this data: "AN IMPORTANT CAUTION: These numbers are based on information provided by the nursing home and are not checked for accuracy. They represent nursing staff levels for a two-week period prior to the time of the state inspection. Because the numbers are not checked and nursing staff levels may have changed since the last state inspection, you should be cautious when interpreting the data."

³⁹ Transcript, President's Saturday Radio Address, September 16, 2000.

Exhibit 12

Mean Staffing Levels in U. S. Nursing Homes Total Hours per Resident Day				
State	1996	1997	1998	1999
Alabama	3.54	3.56	3.73	3.59
Alaska	4.96	5.49	4.92	4.74
Arizona	3.52	3.71	3.74	3.25
Arkansas	2.77	3.03	3.12	3.19
California	3.51	3.57	3.52	3.41
Colorado	3.26	3.39	3.30	3.23
Connecticut	3.00	3.10	3.16	3.15
Delaware	3.73	3.81	4.41	3.88
Florida	3.60	3.64	3.59	3.49
Georgia	3.03	3.10	3.10	3.06
Hawaii	3.92	4.13	4.11	3.83
Idaho	3.97	4.27	4.05	4.28
Illinois	2.86	2.93	3.01	3.10
Indiana	2.80	2.83	2.87	2.94
Iowa	2.68	2.64	2.69	2.74
Kansas	2.56	2.62	2.64	2.69
Kentucky	3.51	3.71	3.59	3.60
Louisiana	3.08	3.21	3.14	3.14
Maine	3.62	3.73	3.88	3.69
Maryland	3.07	3.20	3.34	3.42
Massachusetts	3.46	3.46	3.55	3.45
Michigan	3.20	3.33	3.32	3.32
Minnesota	2.84	2.86	2.84	2.82
Mississippi	3.31	3.52	3.46	3.28
Missouri	3.06	3.05	3.00	3.09
Montana	3.51	3.47	3.57	3.40
Nebraska	2.83	2.93	2.97	3.05
Nevada	3.90	3.70	3.82	4.73
New Hampshire	3.49	3.61	3.73	3.83
New Jersey	3.16	3.18	3.27	3.37
New Mexico	3.26	3.41	3.23	3.03
New York	3.00	2.99	3.06	3.06
North Carolina	3.46	3.64	3.70	3.58
North Dakota	3.24	3.28	3.20	3.52
Ohio	3.43	3.48	3.41	3.52
Oklahoma	2.30	2.64	2.61	2.46
Oregon	3.19	3.14	3.09	3.06
Pennsylvania	3.43	3.58	3.69	3.58
Rhode Island	2.87	3.00	3.03	3.11
South Carolina	3.56	3.65	3.67	3.65
South Dakota	2.65	2.72	2.77	2.66
Tennessee	2.93	3.02	3.21	3.06
Texas	3.14	3.21	3.11	3.01
Utah	3.22	3.28	3.46	3.83
Vermont	3.30	3.32	3.33	3.34
Virginia	3.21	3.31	3.38	3.41
Washington	3.56	3.80	3.74	3.73
West Virginia	3.37	3.7	3.35	3.41
Wisconsin	3.03	3.18	3.13	2.99
Wyoming	3.53	3.25	3.27	3.24

Source: Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes.

In October 2000, the chairman of the U.S. Senate Special Committee on Aging introduced the *Nursing Home Staff Improvement Act of 2000*. The legislation would:

- require the Secretary of Health and Human Services to complete the report to Congress on the appropriateness of minimum nurse staffing ratios in nursing homes by July 1, 2001,
- require the Secretary to issue regulations regarding appropriate minimum caregiver to resident levels and minimum supervisor to caregiver levels for nursing homes within one year of the completion of the staffing report,
- establish a competitive grant program to the states for improving staffing levels in nursing facilities. A grant state may provide technical or financial support to nursing facilities, labor organizations, nonprofit organizations, community colleges, or other organizations approved by the Secretary. This authorizes \$500 million for each of the fiscal years 2001 and 2002,
- require nursing homes to submit accurate staffing information to the Secretary in a form and manner determined by the Secretary. The Secretary will periodically post and update such information on the Nursing Home Compare web site, and
- require nursing homes to post daily the number of licensed and unlicensed nursing staff on duty per shift.⁴⁰

Certified Nursing Assistant Training

Tennessee's training to certify nursing assistants does not lead to continued career development. Consequently, nursing assistants are not in a position to command salaries commensurate with their duties and generally do not remain in jobs that offer little opportunity for advancement. The result has been system-wide staffing shortages, high turnover rates, and under-trained staff. One facility administrator told Comptroller's staff that she has had an annual turnover rate as high as 168 percent, and that 100 percent turnover is common. Administrators say they are hampered by an inability to pay competitive wages, as well as the unappealing nature of nursing care itself and the negativity engulfing the industry.

Most of the direct care in nursing facilities is provided by Certified Nursing Assistants (CNAs). CNAs perform direct contact duties such as feeding, bathing, dressing, grooming, walking, or turning patients and checking vital signs; CNAs may also perform non-direct contact duties such as documenting food and fluid intake or bed making.

CNAs must complete a 75-hour training course and pass a competency exam. Training is most often conducted by the nursing home, using a state-approved curriculum, but is sometimes also provided through the Tennessee Health Care Association. Proprietary occupational schools also provide CNA training. In-house training is cost-efficient for the facilities, since CNAs-in-training can work in facilities for up to four months while preparing for certification testing.

⁴⁰ News Release, the United States Senate Special Committee on Aging, October 6, 2000.

Training is also offered in Tennessee's technology centers and, to a very limited extent, in community colleges.⁴¹ However, the courses are non-credit (for academic purposes), and are not structured to encourage a career path toward LPN or RN training, or to encourage continued professional development within the CNA certification.

Officials at the Tennessee Board of Regents (TBR) indicated that the salaries available to CNAs provide very little incentive for individuals to seek or complete CNA training.⁴² They also indicated that current course offerings within the TBR system were more than sufficient for the demand, and that, in the absence of adjustments to the salary range in the CNA field, expanded or enhanced curricula would not be effective or efficient higher education policy.

Financial Concerns

This section provides an overview of issues with direct financial implications for the state and for owners of nursing facilities. These issues include nursing facility lawsuits, liability insurance, the bed tax, intergovernmental transfers, management fees, revaluation of assets, and the reimbursement system. The section concludes with an outline of a proposed reimbursement model that reduces or eliminates some payments and redirects them to cost centers that directly impact patient care.

Lawsuits and Liability Insurance

Tennessee's nursing homes, like those in other states, anticipate financial difficulties stemming from lawsuits that could jeopardize their viability. The number of lawsuits against nursing facilities in other states has increased in the past two years. The increase has been dramatic in Florida, where one law firm has filed approximately 500 suits. The firm has also opened offices in other states, including Tennessee. According to a report submitted to Florida's Task Force on the Availability and Affordability of Long-term Care, the average size of a nursing home litigation claim in Florida was \$278,737 in 1999, which is 250 percent more than the \$112,351 average claim in the remaining 49 states. In one Florida county, the size of the claims rose from an average of \$311,393 in the early 1990s to an average of \$410,294 in the late 1990s.⁴³ A representative of National Health Care estimated that the average claim size in Florida is now between \$600,000 and \$1 million. He attributes the larger settlements in Florida to that state's patients' rights law which allows nursing home residents to sue for punitive damages and 100 percent of attorneys' fees.⁴⁴ (See 45 for a list of state policy options regarding nursing facility lawsuits.)

⁴¹ Officials at TBR report that two community colleges offer CNA training: Cleveland State Community College and Chattanooga State Community College. Recent enrollment has not been sufficient for either institution to conduct CNA classes.

⁴² Interview with Bernard Johnson (Assistant Vice Chancellor for Operations, Tennessee Technology Centers) and Dr. Kay Clark (Associate Vice Chancellor, Academic Affairs).

⁴³ Final Staff Informational Report to the Task Force on Availability and Affordability of Long-Term Care in Response to House Bill 1993, Florida Policy Exchange Center on Aging, University of South Florida, January 28, 2001.

⁴⁴ Section 400.023, Florida Statutes.

The proliferation of lawsuits has caused insurance companies to raise liability premiums and, in some cases, refuse to cover nursing homes. One national chain's premiums have increased from about \$400,000 in 1992 to around \$8 million in 1999.

Bed Tax

If HCFA disallows Tennessee's bed tax as currently implemented, the state will need to raise approximately \$100 million from other revenue sources in order to maintain federal Medicaid matching funds. On June 15, 2000, HCFA submitted a draft report of the results of its on-site review of the bed tax. In the report, HCFA "preliminarily concluded" that the tax is impermissible because the state reimburses qualifying private pay patients for the tax through state funded grants. The amount of the federal portion of the tax collected, according to the report, was \$455.2 million for the period October 1, 1992, to September 30, 1999. After further review, HCFA concluded in December 2000 that Tennessee's bed tax was indeed impermissible. Tennessee has joined several other states in appealing HCFA's decision.

Intergovernmental Transfers

If HCFA disallows or restricts the use of intergovernmental transfers the state will need to find other sources of revenue to maintain federal Medicaid matching funds. In 2000 the state completed two complex transactions known as Intergovernmental Transfers (IGTs), whereby county owned nursing homes transferred funds to the state and the state then returned those funds to the county nursing homes in the form of a disproportionate share payment.⁴⁵ Tennessee did not execute its IGT until it had first received approval of the appropriate state plan amendment, which it had filed with HCFA. HCFA reviewed the state plan and approved it.

During this period HCFA was studying the IGT process in general, noting that many states had recently requested IGTs for very large amounts. According to HCFA, some states (Tennessee was not among them) were using their IGT money for programs other than long-term care. On October 10, 2000, HCFA issued a proposed rule, which would place certain limits and restrictions on IGTs. The rule has not yet been adopted.

Management Fees

Current reimbursement rules allow non-related nursing home management companies to receive payments that in some cases are not directly related to the services they provide. In such instances, funds are shifted from direct patient contact services to management services. This issue could be resolved by changing Tennessee's reimbursement rules to treat all management companies as related parties for reimbursement purposes, and to reimburse only for documented costs incurred by a management company for its services. Most, if not all, of the management companies have such broad responsibility to operate their nursing homes that defining them as related parties is not unreasonable. Such a change should not be an issue for responsible management companies that are charging reasonable fees for the services they are providing, since the fees should not vary materially from their allowable costs plus a reasonable profit.

⁴⁵ A "disproportionate share payment" is based on the theory that some institutions provide more than their fair share of services based on the relationship between the population to be served and the number of providers.

Revaluation of Assets

Allowing payment of additional capital costs to nursing homes upon change of ownership has no sound financial basis and may result in a reduction of funds available for direct patient contact services. Savings to the state could result, and funds could be redirected to direct patient contact services, if the state were to revert to the original Medicare principle whereby no increases in capital costs were recognized for changes in ownership. It is not reasonable to assume that costs always increase as a result of an ownership change or a leasing arrangement. An acquiring nursing home could retain the reimbursement rate of the purchased provider until such time that the new provider submitted its first cost report.

Nursing Facility Reimbursement

The current reimbursement formula produces no direct incentive to provide care above minimum standards. Tennessee's nursing home payment system could more directly impact quality of care by paying facilities to increase the number and improve the training, career paths, and compensation of personnel who are licensed or certified for direct patient contact. Nursing facilities are reimbursed at the same rate whether they provide substandard, adequate, or optimum care.⁴⁶ One of the specific questions asked by the Human Resources Subcommittee of the House Health and Human Resources Committee was whether the state, in lieu of the current reimbursement plan, "should adopt a Medicaid payment system that pays nursing homes at a higher rate for direct patient care, and reduces payment levels for indirect costs." (See Appendix 1.) To respond in part to that question Division of State Audit staff has developed a budget neutral reimbursement model that increases the value attached to some care processes that involve direct patient contact, and reduces the value attached to some care processes that do not involve direct patient contact. The following is an overview of the current payment plan and the proposed model. The model is outlined in more detail in a memo from Comptroller John Morgan to Representative Arriola.

The Current Payment Plan

The current Medicaid nursing home payment plan has been in place for about 24 years. Most of the modifications to the plan have increased payments to nursing homes. Nursing homes file cost reports each year, which are used to set the Medicaid rates. All costs, regardless of their nature, are treated equally in the rate formula. Allowable costs are stated in terms of a "cost per patient day," which essentially becomes the nursing home's payment rate.

The payment method is known as a "prospective" payment system. Rates are determined from information filed by nursing homes for the current year, but those rates are paid in the following year. They are paid in the future or "prospectively." Rates are generally set each July 1 and are paid through the following June 30th (the state's fiscal year). Once set, rates are not changed until the next July 1 except to correct errors or as a result of audit. Such rates are considered "payment in full." There are no retroactive adjustments.

There are two levels of care, or *acuity levels*, in the present program: Level 1 care (intermediate care) and Level 2 care (skilled care). Level 1 care comprises about 92 percent of Medicaid nursing facility days. Level 2 care comprises about eight percent of

⁴⁶ Facilities that provide substandard care run the risk of incurring fines or other sanctions by doing so.

the Medicaid days. Reimbursement rates are determined separately for each level, though the payment methodology is basically the same for both.

There are administrative advantages of using only two acuity levels. Determining the acuity level, and thus the reimbursement level, is a fairly straightforward process. One disadvantage of this simplified administrative system, however, is that the actual cost of providing quality care can vary significantly within an acuity level. For example, some patients who are approved for Level 2 care may require significantly more resources than the reimbursement level provides, while other Level 2 patients may require significantly fewer resources. In the former instance, the state is not adequately funding the care of the patient and the nursing facility must absorb the extra cost. In the latter instance, the state is paying for care that is not required, and the nursing facility profits excessively.

In an attempt to determine more specifically the appropriate reimbursement level for Medicare patients, the federal government employs a system that correlates a significant number of variables associated with certain health conditions with the resources needed to treat the conditions. The result of that correlation is a set of Resource Utilization Groups (RUGs). The basic methodology of the system is to base reimbursement on the cost of resources (staff, supplies, equipment, etc.) necessary to treat certain conditions. The trend is to increase the number of variables used to make RUG determinations, in effect increasing the number of different reimbursement levels.

Criteria for determining levels one and two for Medicaid-reimbursement under the present system are found in Appendix 9.

Other Rate Components in the Current Payment Plan

In addition to actual cost, the state's present reimbursement method includes three components that are not directly related to quality of care. The three components are the cost increase factor, the cost containment incentive, and return on equity. In the proposed reimbursement model staff adjusted or eliminated these components and redirected savings to a "direct patient contact" personnel incentive based on weighted medical and nursing costs per day.

Cost Increase Factor

The cost increase factor as implemented does not directly link payment to improved patient care. Unlike a traditional inflation factor (such as the Market Basket Index or the CPI), the cost increase factor in the current reimbursement method is not calculated based on an analysis of the cost of a general set of goods and services. Instead, it is calculated based on the expenditures of individual nursing facilities. In that sense it is provider-specific. Under the present system some providers receive an unusually high cost increase reimbursement (such as the 28.3 percent in level 1), while others receive none at all.

The proposed model would eliminate the calculated, provider-specific cost increase factor, and adopt an across-the-board three percent cost increase factor.

Cost Containment Incentive

The cost containment incentive does not give nursing homes an incentive to improve patient care. By definition, just under 65 percent of the nursing homes will automatically receive some computed cost containment incentive.

The proposed model would eliminate the cost containment incentive.

Return on Equity (ROE)

The Return on Equity factor is a function of balance sheet equity for proprietary providers; it bears no direct relationship to quality of care. Medicare has eliminated ROE from its payment formulas but Tennessee retains it in the Medicaid formula. ROE does not benefit all facilities; it is computed only for proprietary providers.

The proposed model would eliminate the Return on Equity component from the reimbursement formula.

Proposed Direct Patient Contact Model

The proposed model recognizes patient care factors and rewards nursing homes for spending on direct patient care without negatively impacting other cost centers. The present Medicaid nursing facility reimbursement methodology does not recognize intensity of illness or quality of care factors. The proposed model is a “modified direct cost” method that avoids the administrative confusion of other such methods by specifically defining cost centers and by providing incentives for those that involve “direct patient contact.”

The suggested model criteria are as follows:

- Develop a budget neutral model. The estimated government expenditures in total should be about the same as under the present system.
- Replace the present cost-containment incentive with a direct patient contact incentive based on medical and nursing/nursing assistant costs, the largest component of which is nursing salaries. Since personnel who are licensed or certified for direct patient contact most directly affect the quality of patient care, an incentive would be provided above some pre-determined standard level of nursing costs.
- Replace the present cost-increase factor with a market basket index that more accurately reflects the effect of true inflation on nursing home costs. Redirect the savings into the nursing/nursing assistant incentive. Retain the present cost-increase factor for purposes of determining the maximum reimbursement rate and determining rates under the present system for analysis and study.
- Eliminate the present Return on Equity factor and redirect the savings into the direct patient contact incentive. Retain the ROE for purposes of determining the maximum reimbursement rate and to determine rates under the present system and for analysis and study.
- For purposes of determining the ceiling rate, the model would retain the present methodology. That would provide for the basis from which to assure budget neutrality with the old system.

Licensure and Certificate of Need

Although *Tennessee Code Annotated* §68-11-207 provides for the suspension or revocation of licenses, the process for renewing nursing home licenses does not consider a facility’s failure to provide quality care. According to a Division of Health Care Facilities official, facilities merely pay an annual fee and the Division renews the license.

The administrator of a facility having immediate jeopardy or actual harm deficiencies, or upon request of the Board, should be required to appear in person before the Board to explain what the facility has accomplished to correct the deficiency and to justify the renewal of the license. The Board would review the renewal applications for facilities having no immediate jeopardy or actual harm deficiencies without requiring the administrator to be present unless the Board requested personal appearance.

To help prevent a recycling pattern, the Board should grant only provisional six-month licenses to facilities whose most recent annual survey or complaint investigation resulted in immediate jeopardy or actual harm deficiencies and to those whose two most recent surveys resulted in substandard care deficiencies. A provisional license should not be granted for more than two successive six-month periods. If the facility has not satisfactorily corrected its operations, the Board should consider the facility ineligible for licensure for a period of one year.

The Certificate of Need (CON) process in Tennessee does not ensure that facilities will provide quality care. Until 1986 the aberrations in market competition created by the CON process were acceptable to Congress, which reasoned that the investments necessary to construct and maintain medical facilities were significant and were in essence underwritten by taxpayers through the Medicare and Medicaid programs. The theory of the CON was that removing competition in health facilities markets would reduce costs in the long term by managing extreme capital costs. The **quality of the physical elements** of medical facilities has not been at issue, since in fact some of the extreme costs associated with medical facilities arose from technological innovations that directly improved the quality of medical procedures. There was a tacit assumption in this process that the **quality of service** provided by medical facilities would not suffer from reduced competition, since quality was maintained by the implicit standards of health care professionals and the explicit standards of various accrediting mechanisms.

The primary effect of lack of competition is reduced choice; a secondary effect can be reduced quality. For consumers of nursing facility services, this is true whether reduced competition exists because of a CON process or because of supply-side factors. This lack could be addressed in some instances by assisted living facilities and home-based and community-based care. However, when a consumer needs services that only a nursing facility can provide, and the sole provider within a service area renders deficient care, lack of choice becomes a significant issue.

Organizations wishing to construct, develop, or establish a health care institution or otherwise increase or redistribute existing beds in Tennessee must apply for a CON from the Tennessee Health Facilities Commission. The Commission holds public hearings to allow testimony from advocates or opponents of the facility. Upon being awarded a CON, the organization must implement its provisions within two years or the certificate of need is void. The CON remains in effect so long as the facility retains its license.⁴⁷

⁴⁷ Interview with Linda Penny, Executive Director, Tennessee Health Facilities Commission, July 27, 2000.

The certificate of need program started as a federal health planning program established in 1974 to stop unnecessary health facility construction and acquisition of major medical equipment. Under the Reagan administration, a phase-out of the program gradually reduced federal funding until November 1986 when Congress repealed the legislation that created the program. Since the federal government no longer requires a CON process, 14 states no longer have such programs and four states are considering doing away with them. Tennessee has retained its program.⁴⁸

The last two performance audits of the Commission contained findings that the accuracy of applicant-supplied information is not ensured or independently verified. The 1994 audit contained the following statement: “The accuracy of information used as the basis for Tennessee Health Facilities Commission decisions to grant or deny a Certificate of Need is not ensured because (1) Department of Health reviewers do not always indicate which information in the application has been verified and with what source it has been verified and (2) information compiled by the Department of Health through self-reporting by providers, which is used for verifying applicant-provided information, is not verified or up-to-date.”⁴⁹ At recent Commission meetings, members have expressed concerns about not having a current State Health Plan or current information.

Role Coordination

In Tennessee, authority and responsibility for overseeing the health care industry rests with multiple agencies, resulting in an uncoordinated, duplicative, and sometimes uncooperative and conflicting, system of care to vulnerable senior citizens. The agencies with primary responsibility for nursing home regulation are the Division of Health Care Facilities within the Department of Health, the Division of Long-Term Care within the Bureau of TennCare, and the Health Facilities Commission. If done with the best interest of Tennessee’s patients in mind, combining the functions of the these agencies into a single Health Care Facilities Authority, structured in a manner similar to the Tennessee Regulatory Authority, could promote a more concerted effort to improve not only the regulation of nursing homes, but other health care providers as well.

While primary responsibility rests with the agencies listed above, other local and state entities are involved with various aspects of nursing home concerns. These agencies include the Ombudsman Program, Adult Protective Services, the Tennessee Bureau of Investigation, local law enforcement, and a multi-agency statewide working group established through an initiative of the U.S. Department of Justice to protect nursing home residents from abuse and neglect. Because the duties of these agencies overlap with other functions, they should not be included in a single regulatory agency.

Some agency representatives indicated to Comptroller’s staff that they often experience difficulties in obtaining information from each other. For example, Tennessee Health Facilities Commission members have expressed concern about not having a current State Health Plan or other current information. Persons interviewed described other processes that result in a duplication of effort or in ineffectual attempts to perform their duties. For instance, Division of Health Care Facilities staff do not know the status of

⁴⁸ Health Policy Tracking Service Issue Brief, *Certificates of Need*, May 22, 2000.

⁴⁹ Ibid.

recommendations for civil monetary penalties that have been appealed to the Long-Term Care Services Division in the Bureau of TennCare.

Volunteer ombudsmen serve a valuable function by acting as advocates for nursing home residents and by conducting regularly scheduled visits. However, ombudsmen have no regulatory authority. Residents are encouraged to bring complaints to volunteer ombudsmen, who then must decide whether the complaints they receive are within their power to resolve or should be referred to an agency with regulatory authority. This process can resolve minor issues quickly, and can prevent minor problems from becoming major ones. The decision whether to refer problems or complaints to regulatory agencies is a crucial one.

TCA §71-2-111 establishes a Long-Term Care Ombudsman Program within the Tennessee Commission on Aging to carry out certain provisions of the federal Older Americans Act. The Act created the ombudsman program and authorized ombudsmen to identify, investigate, and resolve complaints that are made by or on behalf of residents of long-term care facilities, to assist residents to protect their health, safety, welfare, and rights, and to inform residents how to obtain services.

The Commission employs a full-time professional long-term care ombudsman who oversees the activities of nine district ombudsmen working in area offices on aging. According to statute, district ombudsmen may be either full-time or part-time employees; it is commission policy that they be full-time employees. Because of the high number of facilities and the low number of district ombudsmen, the paid ombudsmen rely on trained volunteers to work with and on behalf of persons residing in nursing facilities, assisted living facilities, residential homes for the aged, and other similar types of homes or institutions (over 700 facilities). The program has a goal of visiting long-term care facilities weekly.⁵⁰ The AARP assists the program by recruiting a significant number of volunteer ombudsmen.⁵¹

The ombudsmen program is not affiliated with either the nursing home administration or any of the various regulatory authorities. For this reason it provides a valuable third party presence in nursing facilities.

The responsibility of Adult Protective Services (APS) within the Department of Human Services to investigate abuse and neglect of nursing home residents appears to duplicate the duty of the Division of Health Care Facilities. HCFA requires the Division of Health Care Facilities to investigate complaints against nursing facilities, including allegations of abuse and neglect. Additionally, the Tennessee Adult Protection Act [TCA §71-6-101, et seq.] places responsibility for protecting certain vulnerable adults from abuse, neglect, or exploitation with the Tennessee Department of Human Services. Adult Protective Services programs do not operate under federal regulations as do the state survey agencies; each state writes its own laws and each implements adult protective services under its own requirements.⁵²

⁵⁰ Interview with James Whaley, Executive Director, Tennessee Commission on Aging, June 20, 2000, and correspondence, March 2, 2001.

⁵¹ Interview with Chad Miller, State Director, and Brian McGuire, Advocacy Representative, AARP, July 28, 2000.

⁵² Interview with Marilyn Whalen, Director of Adult Protective Services, Tennessee Department of Human Services, August 4, 2000.

While the Department of Human Services investigates cases of abuse, neglect, or exploitation in nursing homes and other types of institutions, such as mental retardation facilities, the Director of Adult Protective Services stated that the majority of cases it looks into are those involving the self-endangerment of an elderly person living alone. The Adult Protection Act currently requires reports to APS by anyone, including hospital staff, who observe suspicious injuries. What may be missing from the reporting process is a consistent method of screening on admission.⁵³ Once APS accepts a case for investigation, it is required to report it to local law enforcement; local law enforcement may or may not become involved in the case.

Adult Protective Services does not have the capacity to investigate cases on holidays, weekends or after business hours, although persons can report allegations to a 24-hour number. Given that the over-riding purpose of facility regulation is patient protection, removing responsibility for APS to investigate cases in nursing homes should not diminish the state's efforts to protect nursing home residents. Removing this responsibility would allow APS counselors to devote more resources to other client areas, and would help to establish the department's clear responsibility to serve nursing home residents.

Nursing Home Posting Requirements

Although guidelines require that nursing homes post specified information, a standard format applicable to all nursing homes does not exist, sometimes resulting in difficulty for individuals to determine how to obtain information. HCFA requires nursing homes to provide access to telephone numbers for the state survey agency and the local ombudsman program as well as the results of the last facility survey. TCA §68-11-254 requires standard information to be posted; however, there is no standard format. The result is often ambiguity about whether a facility has fulfilled posting requirements. In addition, individuals may not be able to tell how best to initiate complaints or to request information. A standard information poster would allow survey teams quickly to check compliance with posting requirements and could more efficiently direct citizens who need assistance to the appropriate agency.

⁵³ Correspondence, Natasha Metcalf, Commissioner, Department of Human Services, March 1, 2001.

Recommendations

Legislative

Agency Consolidation

The General Assembly may wish to consolidate the functions of the Board for Licensing Health Care Facilities, the Department of Health's Division of Health Care Facilities, the Health Facilities Commission, and TennCare's Division of Long-Term Care into a single Health Care Facilities Authority. Currently, authority and responsibility for regulating the health care industry rests with three separate agencies, resulting in an uncoordinated, and sometimes uncooperative and conflicting, system of care to senior citizens. If done with the best interest of Tennessee's patients in mind, bringing these three agencies together could promote a more concerted effort to improve not only the regulation of nursing homes, but other health care providers as well. Having a single agency would remove all doubt about where ultimate responsibility for health care facilities lies. Consolidation would also present an opportunity to change the culture of facility regulation from being facility-centered to being patient-oriented.

This Authority could be similar in structure to the Tennessee Regulatory Authority with full-time paid directors appointed by the Governor and the Speakers of the Senate and the House.

Comments: Division of Health Care Facilities

The missions of TennCare and the enforcement division are very different. The two divisions were together several years ago, but were not effective.

Because of the differences of responsibilities between TennCare and Healthcare Facilities, combining the divisions would not insure improvements in communications and/or completion of tasks. Prioritizing the required work and reassigning tasks could be addressed within the current management structure.

In 1995 HCFA combined the Medicaid and Enforcement divisions in Atlanta under one management structure; however, HCFA has recently begun the process of reverting to separate divisions.

Comptroller's Response

The Bureau of TennCare (including the Division of Long-Term Care) and the Division of Healthcare Facilities were located in the Department of Health at the same time and ultimately reported to the Commissioner of Health, who had responsibilities for a wide variety of health-related services. Under the model proposed in this report, responsibilities for a Health Facilities Authority would focus solely on facilities.

Comments: Bureau of TennCare

The Division of Long-Term Care strongly disagrees with this recommendation. It should be noted that the services administered by the Division of Long-Term Care are Medicaid State Plan Services. Federal regulations found at 42 CFR § 431.10 require designation of a Single State Agency for administration and supervision of administration of the State Plan. Federal regulations would not allow the Single State Agency to delegate certain administrative functions to the consolidated agency described in the recommendation, including eligibility determination and rule and policy making. Both of these functions are performed by the Division of Long-Term Care; therefore, the Division should remain

within the Single State Agency. In addition, all claims processed for federally funded Medicaid programs are required to be processed through the MMIS system, which is maintained by TennCare.

The Division further suggests that it needs to remain within the TennCare Bureau to ensure adequate coordination of TennCare MCO/BHO and pharmacy services with long-term care services.

The Division agrees that better coordination between state agencies is desirable. The Long-Term Care Director has requested improvement positions to establish a Long-Term Care Quality Monitoring Unit. One of the positions within the proposed unit is designated as an institutional quality coordinator. Job responsibilities will include ensuring coordination with the Division of Health Care Facilities and development of policies to ensure timely processing of civil monetary penalty appeals. The Long-Term Care Director has discussed the importance of resolving outstanding appeals as soon as possible with the TennCare Office of General Counsel and with the TennCare Office of General Counsel attorney assigned to provide consultation to the Division of Long-Term Care.

The Long-Term Care Director suggests the establishment of a state work group with representatives from all agencies involved in the provision of long-term care services. Such a work group, meeting on a regularly scheduled basis, could provide a mechanism of ensuring more effective communication and coordination between agencies.

Comptroller's Response

Placing the functions of the Division of Long-Term Care under the administrative umbrella of a single health care regulatory authority could be accomplished within the limits of federal law by allowing the Bureau of TennCare to retain responsibility for promulgating policy and for providing oversight through routine review.

Consolidating functions within a centralized entity would create a clear line of administrative accountability for all official activities involving health care facilities. The fragmentation of authority and responsibility in the current organizational structure makes it difficult for the General Assembly to develop health care policy. Moreover, the intricacy of the network of responsible agencies makes it difficult for citizens to “use” the system to resolve issues with health care facilities.

Annual Facility Reports

The General Assembly may wish to consider requiring standard annual facility reports from the Division of Health Care Facilities or any successor agency. The report should include explanations of each field and the significance of each field value. The report should also include a statistical analysis for each facility [e.g., correlations of significant variables, such as ownership and survey performance] and a summary analysis [e.g., ranking of each facility by relevant fields]. Such a report could be produced using existing data sources within the department and by arrangement with HCFA. The purpose of this report would be: (1) to assist the department in focusing its resources on those facilities with operational problems; (2) to inform the General Assembly of the status of nursing facilities; (3) to inform individual facilities and facility organizations of the status of nursing facilities. (See Appendix 7 for a suggested minimum field list.) The report could be expanded in the future to include a census and analysis of other providers of

elder care, including assisted living facilities, and home and community based service providers. Trend analysis of this type of data could assist the General Assembly with long-term care policy decisions.

Comments: Division of Health Care Facilities

We agree. The Division feels such reports to the General Assembly would be beneficial. For an in-depth analysis and trending of the data, additional staff would be needed.

Facility Monitor Positions

The General Assembly may wish to consider modifying TCA §68-11-221 to allow for the creation of facility monitor positions. Personnel in such positions would have the full authority and training of surveyors, and would be responsible for visiting nursing facilities for spot checks of operations and conditions. Facility monitors could cite deficiencies, could accept plans of correction for submission to and approval by a full survey team or supervisor, and could call for immediate full surveys.

Comments: Division of Health Care Facilities

The Division of Health Care Facilities believes that implementing this recommendation would require significant resources.

Correction of Deficiencies

The General Assembly may wish to consider directing the Division of Health Care Facilities or any successor agency to develop a process by which deficiencies are corrected immediately and monitored for a reasonable period of time, subject to the nature of the deficiency, by department personnel, with a portion of the cost of such supervision to be paid by the facility.

Such a process would improve the integrity of the annual survey and of complaint investigations by placing a greater responsibility upon the surveyors and investigators to identify deficiencies consistently, since deficiency citations would result in immediate action. Such a process would also place the well-being of the nursing facility resident ahead of other considerations or activities that might be initiated by deficiency citations. An appeals process could be left in place with provisions for repayment of costs if the facility were found not to have violated standards.

Comments: Division of Health Care Facilities

The Division of Health Care Facilities believes that increasing the monitoring by survey staff of facilities with any cited deficiencies would dramatically increase the cost both to the state and the facility. The cost could be limited if monitoring is reserved for those facilities cited with substandard care in areas of quality of life and/or quality of care.

Acuity Data and Case-Mix Analysis

The General Assembly may wish to require the Division of Health Care Facilities or any successor agency to prepare facility reports that compare admissions acuity data with acuity data for long-term stay patients. Such a report could help identify acuity changes at individual facilities. For a similar analysis of case-mix characteristics in their report to Congress, HCFA used Medicare admissions data (which could be obtained in Tennessee from Pre Admission Evaluation forms) and Minimum Data Set data (which

HCFA could make available to the department).⁵⁴ Requiring such a report should also improve the integrity of the data recorded on the Pre-Admission Evaluation and Minimum Data Set, since the quality of a facility's service delivery could be defined, in part, by the results of such an analysis. Currently, the data available from the PAE and MDS data sets is not always complete and not always reliable.

Resident Protection Trust Fund

The General Assembly may wish to consider amending *Tennessee Code Annotated §68-11-827* to make the Resident Protection Trust Fund available for community programs that directly and significantly increase community involvement with nursing facilities. Too often nursing home residents are isolated from life outside the facility. Grant recipients could use grant funds for a variety of purposes such as hiring volunteer coordinators to oversee visitation programs or developing programs to involve residents in community activities. The department could receive and consider proposals from community groups or advocacy organizations to provide community presence and participation in nursing facilities. The objective of the grant program would be to bring daily community life into nursing facilities.

Direct Patient Contact Personnel

The General Assembly may wish to mandate existing resources or appropriate new nursing home resources to positions involving direct patient contact. This recommendation is offered to provide an interim solution to the current reimbursement method, which does not offer sufficient incentives to provide quality care at the patient contact level. The first available resources (whether re-directed or newly appropriated) should be devoted to increasing the number and improving the quality of personnel within the system who are certified and/or licensed to provide direct patient contact.

Certified Nursing Assistant Training

The General Assembly may wish to consider directing the Board of Regents to expand and enhance the Certified Nursing Assistant curriculum to make it appropriate for community colleges and technology centers. [This recommendation is made with the provision that other policy changes result in an upward adjustment of the salary of CNAs. Individuals are not likely to take advantage of expanded opportunities in the CNA profession unless salaries are increased.] A CNA curriculum that served as an introduction to the LPN or RN curriculum might act as an incentive for individuals to undertake and complete CNA training. Curriculum and training within the Board of Regents system would accomplish several purposes: (1) it would add prestige to the CNA occupation; (2) it would standardize training across the state; (3) it would encourage innovation by exposing trainees to other, similar disciplines (e.g., emergency medical technicians); (4) it would encourage innovation by exposing the CNA occupation to instructors within the Board of Regents system; and (5) it would publicize the opportunities within the occupation to students in other disciplines.

⁵⁴ See *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes*, p. 12-6.

Nursing Facility Lawsuits

The General Assembly may wish to consider the following policy options to address the issue of nursing facility lawsuits. Several possible effects could emerge if lawsuits against nursing facilities proliferate in Tennessee as they have in Florida.⁵⁵ If an increase in the number and magnitude of awards and settlements occurs in Tennessee as it has in Florida, the cost of doing business as a nursing facility will increase. The cost could be absorbed either by the stockholders or other owners of facilities, by the state, by the residents of facilities (in the form of reduced services), or by a combination of any or all of these entities. Organizations representing nursing facilities have indicated that the cost of defending or negotiating lawsuits and the cost of indemnifying against lawsuits necessarily represents a reduction in the resources available to provide quality care to nursing facility residents.

Several policy options are available to the General Assembly to address the issue of nursing facility lawsuits:

- **Correct Deficiencies:** Reduce the grounds for lawsuits by introducing measures to reduce the occurrence of deficiencies in nursing facilities and to ensure that cited deficiencies are corrected as soon as possible.
- **Laissez Faire:** Allow the current statutes to stand, and let the effects of litigation (should it occur) emerge more clearly in the economy of the nursing facility system.
- **Medical Malpractice Statutes:** Define more specifically the nature and degree of negligence that would provide grievance.
- **Limit of Attorneys' Fees:** Limit the amount of attorneys' fees in suits against nursing facilities. This would reduce the monetary incentive to litigate. It would also reduce deterrent and punitive effects of possible lawsuits for substandard care.
- **Limit of Awards:** Limit the amount of awards in suits against nursing facilities. This would reduce the monetary incentive to litigate. It would also reduce deterrent and punitive effects of possible lawsuits for substandard care.
- **Increase Allowable Cost of Insurance:** Increase the allowable cost of liability insurance in the reimbursement formula. This would most likely reduce the market effect of competition among insurance providers and would result in increased costs to the state.

Direct Patient Contact Reimbursement Model

The General Assembly may wish to consider adopting a reimbursement method that directs resources to facility personnel who provide direct patient contact services.

The proposed model provides one example of a method that redirects funds from costs that do not directly affect quality of care to costs for licensed and certified personnel. Improving the quality and increasing the quantity of facility personnel who are licensed and/or certified for direct patient contact should result in improvements in quality of care.

⁵⁵ Staff remarks are not intended as a comment on the merit of lawsuits in general or any specific lawsuit against nursing facilities.

License Renewal Process

The General Assembly may wish to consider amending *Tennessee Code Annotated §68-11-201, et seq.*, to require nursing homes to apply for re-licensure to the Board for Licensing Health Care Facilities annually. Rather than renew licenses by merely paying a fee to the Division of Health Care Facilities or any successor agency, the administrator of a facility having immediate jeopardy or actual harm deficiencies, or upon request of the Board, should be required to appear in person before the Board to explain what the facility has accomplished to correct the deficiency and to justify the renewal of the license. The Board would review the renewal applications for facilities having no immediate jeopardy or actual harm deficiencies without requiring the administrator to be present unless the Board requested personal appearance.

To help prevent a recycling pattern, the Board should grant only provisional six-month licenses to facilities whose most recent annual survey or complaint investigation resulted in immediate jeopardy or actual harm deficiencies and to those whose two most recent surveys resulted in substandard care deficiencies. A provisional license should not be granted for more than two successive six-month periods. If the facility has not satisfactorily corrected its operations, the Board should consider the facility ineligible for licensure for a period of one year.

The statute should contain a due process procedure for nursing facilities contesting Board decisions.

Comments: Division of Health Care Facilities

Agree. The Division could implement this recommendation with no increase in funding. The language in the law would need to be modified.

Certificate of Need Process: Survey Results Reviewed

The General Assembly may wish to consider directing the Tennessee Health Facilities Commission or any successor agency to review state agency surveys before granting a Certificate of Need. The intent of this review would be to discourage owners from expanding existing facilities or acquiring new facilities until they have demonstrated the ability to correct cited deficiencies.

Comments: Division of Health Care Facilities

Agree. This could be incorporated into the current review done by the Department with no additional cost. We will begin adding this to the review process immediately.

Competitive Certificate of Need Process

The General Assembly may wish to direct the Tennessee Health Facilities Commission or any successor agency to develop a competitive CON process that would be applicable within areas served by facilities that demonstrate patterns of substandard care. The intent of this process would be to deter facilities from providing substandard care and to provide alternatives for consumers of nursing facility services.

Comments: Health Facilities Commission

The Commission is committed to exploring the proposals presented in this report. It is the policy of the Commission to support the establishment and the development of healthcare services which are orderly, necessary and economical.

Abuse and Neglect Investigations

The General Assembly may wish to consider removing responsibility for investigating allegations of abuse and neglect of nursing home residents from the Department of Human Services Division of Adult Protective Services. Such a move would prevent misunderstandings of jurisdiction, establish accountability, promote efficiency of response, and employ the specific abilities and expertise of the various other agencies involved. The Division of Health Care Facilities is responsible for investigating all complaints in nursing homes, including those alleging abuse and neglect. Removing this responsibility from Adult Protective Services would eliminate duplication.

The Division of Health Care Facilities or any successor agency should arrange for appropriate staff training and be given statutory authority to:

- investigate allegations of exploitation and self-neglect in nursing homes as well as abuse and neglect,
- investigate when an alleged perpetrator is not an employee of the nursing home,
- secure an injunction prohibiting the perpetrator from having contact with the victim,
- secure an injunction prohibiting the perpetrator from future caregiving in any capacity for a vulnerable person,
- secure an order to provide services to a victim who lacks the mental capacity to make decisions regarding their care, and
- notify law enforcement.

Adult Protective Services should still have the responsibility, however, to forward such abuse or neglect referrals it receives to the Division. Moreover, all relevant agencies, including local law enforcement, should support the Division upon request in assisting nursing home residents needing emergency protection. The TBI should retain responsibility for investigating abuse and neglect cases involving criminal activity as required under its contract with HCFA.

Comments: Department of Human Services

While there may have been some duplication in the past, in recent years duplication of effort has been minimized by conducting joint investigations and sharing information as directed in the memoranda of understanding between the Department of Health and the Department of Human Services.

Administrative

Surveyor Staff

The Division of Health Care Facilities or any successor agency, in cooperation with the Department of Personnel, should develop and employ staff recruitment and retention strategies for surveyors and other relevant staff. The Division has inadequate staff resources to conduct annual surveys and respond to complaints in the timely, efficient, and effective manner required by HCFA. According to department officials, Division management is experiencing considerable difficulty in recruiting and retaining survey staff, particularly registered nurses. In 2000, the General Assembly appropriated funds to create nine new survey positions. In early January 2001, the

Department of Personnel approved the positions and Division management is working to fill them.

Comments: Division of Health Care Facilities

The Division of Health Care Facilities agrees. In order to improve in this area, we have requested additional RN surveyor positions in the 2001-2002 improvement budget. We continue to have difficulties with retention of surveyors due to lack of competitive salaries. Within the past one and one-half years we have implemented the following strategies: long term care differential for survey staff; increased money for staff training; differential for the PHNC 1 staff; flexible work hours; contracted with retired employees to assist with complaint investigations.

Survey Equipment

The Division of Health Care Facilities or any successor agency should provide survey teams with data collection equipment, and put systems in place to ensure the equipment's efficient and effective use. Such equipment would include: (1) laptop computers for recording and transferring survey data; (2) hard disk or CD based reference material for regulations, protocol, survey histories, etc.; and (2) digital cameras for recording evidence of deficiencies.

Comments: Division of Health Care Facilities

This has been completed. All surveyors have either a laptop or desktop computer and have been provided the necessary training to operate. Disposable cameras have been purchased for each regional office for survey staff to use. Digital cameras will be purchased as budget allows.

Comptroller's Response

During a survey in August 2000, Office of Research staff observed that the initial recording of information by surveyors was done by hand for later transcription. Reference materials used were in paper form; no hard disk or CD based reference materials were used. No cameras were used.

Data Analysis

The Division of Health Care Facilities or any successor agency should establish a data analysis unit to provide management information to the Division's administrators. The Division maintains an abundance of data related to nursing home conditions across the state. Analyzing this data on a regular basis would enable the Division to focus its efforts and resources on problem facilities.

Comments: Division of Health Care Facilities

We agree with recommendations; however the Division is limited due to the need of a position to do analysis.

Complaint Database

The Division of Health Care Facilities or any successor agency should maintain its complaint database as a tool to accomplish the following objectives: (1) to meet the needs of residents of nursing homes; (2) to satisfy HCFA requirements; (3) to focus department resources; (4) to manage department survey and complaint investigation personnel; and (5) to educate the General Assembly, individual nursing facilities, nursing facility organizations, and the public. The current

complaint data is distributed across databases in three regions. Data is difficult to retrieve and analyze.

Comments: Division of Health Care Facilities

The Division is in the process of improving the tracking and compiling of this data. As we implement the Federal Data Base System, collecting and recording of this data will change. The long-term care portion of this system is scheduled for implementation in Fall 2001.

Immediate Correction of Deficiencies

The Division of Health Care Facilities or any successor agency should assume the initiative in ensuring that the correction of cited deficiencies is undertaken immediately and achieved in a timely manner. Although plans of correction are required for cited deficiencies, they are often *pro forma*, and may not be evaluated for implementation or effectiveness until the next annual survey. Moreover, the correction of the deficiency often becomes less important to the nursing facility than defending itself, via the appeals process, against any monetary sanction that may accompany the citation. The Division, using existing personnel or the facility monitors proposed in this report, should more closely monitor corrective procedures and outcomes.

Minimum Data Set Analysis

The Division of Health Care Facilities or any successor agency should prepare for analysis of Minimum Data Set (MDS) data. MDS data is provided by facilities and is a periodic report on each resident's condition. The importance of case mix in efficient facility operation and in the equitable distribution of Medicaid funds will increase significantly in the near future. (See discussion of staffing, page 26.) HCFA has already begun a more sophisticated analysis of MDS data to provide information for the distribution of Medicare funds based on the cost of care for specific conditions. The process is similar to using Diagnostically Related Groups (DRGs) for reimbursement. However, because data collection and analysis capability has increased, reimbursement can be much more "patient specific" than under a DRG system.

Comments: Division of Health Care Facilities

The Division of Health Care Facilities agrees. However, analyzing MDS data would require an additional staff person with this expertise or additional monies to contract for this service.

Ombudsman Program

The Commission on Aging could enhance the effectiveness of Tennessee's Ombudsman Program in the following ways:

- Establishing clear lines of communication between volunteer ombudsmen and agencies with regulatory authority could help prevent errors of omission by the ombudsmen. Ombudsmen receive training as advocates. However, they should not be required to make critical decisions relative to patient care, nor should there be any risk that nursing home residents and their families would rely solely upon individuals with no regulatory authority to resolve situations involving substandard care. Ombudsmen should have ready access to individuals and agencies with the expertise

to make judgments regarding patient care and with the authority to intervene where situations warrant official intervention.

- Expanding the duties of the district ombudsmen to include organization of programs designed to increase community involvement in nursing homes could utilize the advocacy talents of the volunteers and capitalize on the volunteer spirit of the ombudsman program.
- Employing paid ombudsmen (in addition to the paid district ombudsmen) to work with individual nursing homes and community groups to organize programs designed to increase community involvement in the nursing homes could be a cost-efficient way to accomplish this goal.

Comments: Commission on Aging

The Commission concurs with the recommendation for additional paid staff in the Long-Term Care Ombudsman Program. Additional paid staff will strengthen the program. However, additional resources will be required to implement the recommendation.

Standard Information Poster

The Division of Health Care Facilities or any successor agency should, by rule, develop a standard information poster for posting in nursing facilities. Federal guidelines require nursing homes to provide access to telephone numbers for the state survey agency and the local ombudsman program as well as the results of the last survey. TCA §68-11-254 requires additional information to be posted; however, the information is not always clearly presented.

A standard information poster for Tennessee would list the various state and local contact agencies (e.g., TBI, Department of Health, Regional Ombudsman, etc.) and methods of contact (e.g., phone numbers, addresses, email, etc.). The poster would also give specific directions for viewing survey results in the facility and for obtaining individual copies of survey results, as well as contact information for more complete survey histories, lists of sanctions imposed (if any), and other details.

Mecklenburg County, North Carolina, has implemented a new program to assist its elderly population. Entitled “Just 1 Call,” the service incorporates a “one-stop source of information and assistance for senior citizens and adults with disabilities” and includes a local phone number, a toll free long distance phone number, and a web site. Personnel are trained to assist elderly and disabled individuals, and individuals who speak languages other than English.⁵⁶

Comments: Division of Health Care Facilities

The Division of Health Care Facilities will immediately begin working on developing a standardized poster and the necessary amendments to the rules and regulations to effectuate this change. The Department has already begun working on a centralized complaint process with a toll free number. Implementation is planned for April 2001. A web site will be accessible for filing complaints as well.

⁵⁶ Brochure, Department of Social Services, Charlotte/Mecklenburg County, North Carolina, from The Gore Family ReUnion: Families and Seniors Across the Generations.

Appendices

- Appendix 1 Letter from Representative Arriola to Comptroller Morgan
- Appendix 2 Persons Interviewed
- Appendix 3 Glossary
- Appendix 4 Nursing Facility Ownership or Control
- Appendix 5 States with regulations exceeding federal minimum requirements
- Appendix 6 Nursing Home Initiative: HCFA's Implementation Chronology
- Appendix 7 Suggested Minimum Field List for Facility Report
- Appendix 8 Decision Making Process Map
- Appendix 9 Criteria for Medicaid-reimbursed Levels One and Two

Appendix 1

Letter from Representative Arriola to Comptroller Morgan

House of Representatives
State of Tennessee

MEMBER OF COMMITTEES

COMMERCE

HEALTH AND HUMAN RESOURCES
SELECT COMMITTEES ON RULES

LEGISLATIVE OFFICE

17 LEGISLATIVE PLAZA
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March 2, 2000

The Honorable John Morgan
Comptroller of Tennessee
State Capitol
Nashville, Tennessee 37243

Dear Mr. Morgan:

During the 101st General Assembly, Second Session, the subcommittee of Human Resources has heard testimony regarding the state of nursing homes in Tennessee. As chairman of the subcommittee we are concerned about our nursing homes.

We request your office to prepare a report reviewing the adequacy and enforcement of existing nursing home quality of care standards and related issues involving Medicaid payment for nursing facility services.

The report should consider the following:

- The state's nursing facility inspection practices, including the lack of any surprise aspect thereof and reporting of staffing deficiencies.
- The state's use of civil monetary penalties (CMPs) and the review of appeals of such penalties.
- The state's use of the resident protection trust fund moneys that come from collection of monetary penalties.

- Whether the current Medicaid payment system rewards high quality care and discourages care which does not meet quality standards.
- Whether the current Medicaid payment system discourages facilities from serving the sickest patients.
- Whether the state can better integrate quality assurance factors into the Medicaid payment system.
- Whether the state should adopt a Medicaid payment system that pays nursing homes at a higher rate for direct patient care, and reduces payment levels for indirect costs (e.g., lease-back arrangements, trade association dues, management contracts, etc.)
- Whether enforcement efforts could be improved by tracking the compliance records of companies, partnerships and principal investors that own more than one facility, and whether to grant or withhold certificates of need or other increases in facility capacity.
- Whether there should be a mechanism for reviewing the health status of nursing facility residents transferred to hospitals, to assess whether their condition is suggestive of abuse, neglect or poor care in the nursing facility.
- Whether the law should be strengthened by tightening current requirements that nursing facilities report adverse incidents affecting resident care, including instances of inadequate staffing non-compliance with resident rights and quality requirements.
- Whether facilities that fail to report adverse incidents as required, and the corporations, partnerships and principals own them, should be subject to sanctions.
- Whether the state consistently refers cases of neglect or abuse to law enforcement officials.
- Whether current laws are adequate to deter facilities from committing Medicaid fraud or resident abuse and neglect.
- Whether nursing facility staffing patterns are adequate to meet residential needs.

- Whether the state should require nursing facilities to publicly post notice of an adverse action against the facility.

If you have any question on this matter, please call me at 741-1852.

Thank you.

Sincerely,

A handwritten signature in black ink, appearing to read "John Arriola". The signature is fluid and cursive, with a long horizontal stroke at the beginning and a vertical stroke at the end.

JOHN ARRIOLA
State Representative
53rd District

Appendix 2

Persons Interviewed

Martha Anderson, Administrator
NHC-Hendersonville

William Benson, Special Agent in Charge
Medicaid Fraud Control Unit
Tennessee Bureau of Investigation

Gordon Bonnyman, Executive Director
Tennessee Justice Center

Davine Brasher, R.N.
Public Health Nurse Consultant
Division of Health Care Facilities

Dr. Kay Clark
Associate Vice Chancellor
Academic Affairs
Tennessee Board of Regents

Gerald Coggin, Vice President
National HealthCare Corporation

Rick Collier, EMS Director
Volunteer State Community College

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Appendix 3

Glossary

- Abuse or neglect – the infliction of pain, injury, or mental anguish or the deprivation of services by a caretaker which are necessary to maintain the health and welfare of an adult or a situation in which an adult is unable to maintain his own health or welfare.
- Abuse Registry – a registry maintained by the Department of Health that contains the names of any persons who have been determined to have abused, neglected, or misappropriated the property of vulnerable individuals.
- Accreditation – official acknowledgement given by an accreditation organization that a health care provider or supplier meets the specific health and safety standards established by the accreditation organization for that provider or supplier type.
- Activities of Daily Living (ADL) – examples include dressing, bathing, grooming and feeding.
- Acuity Level – a measure of the health condition of a patient. The higher the acuity level, the more resources are necessary to provide quality care.
- Assisted-care Living Facility – a facility providing room and board and assistance with daily living activities for primarily aged persons who may need some assistance with certain medical services that usually can be self-administered.
- Certification – a designation from HCFA that a facility is in substantial compliance with regulations and is allowed to participate in the Medicare and Medicaid programs.
- Certificate of Need (CON) – a permit granted by the Health Facilities Commission for the establishment or modification of a health care institution, facility, or covered health service at a designated location.
- Civil Monetary Penalty (CMP) – a sanction that can be imposed against nursing facilities under circumstances outlined in statute and/or the federal Nursing Home Reform Act of 1987.
- Complaint Survey – on-site inspection conducted by Federal Regional Office staff or State Agency surveyors to investigate an allegation against Medicare or Medicaid providers and suppliers.
- Deficiency – a provider or supplier violation of an applicable program requirement.
- Dual Participation – simultaneous participation of a facility in the Medicare and Medicaid programs.
- Home Health Agencies – provide health care services in the patient’s home that may include nursing care; physical, occupational, or speech therapy; medical social services; homemaker services; and medical supplies and equipment.
- Homes for the Aged – generally home-like facilities for permanent care that are not licensed to provide nursing care and may not accept residents needing medical care; provide room, board, and personal services for non-related elderly persons.

- Hospice Care – provides 24-hour, seven-day/week end-of-life care and family support during the expected final months of a patient’s life; may be provided in the patient’s home or in a residential setting. This is sometimes referred to as palliative care.
- Levels of Care -- the range of services provided within a specific type of health care facility and/or the range of services needed by an individual receiving health care.
- Licensure – a designation by the state that an organization has legal permission to operate.
- Minimum Data Set (MDS) – medical information about each nursing home resident collected periodically by nursing homes and reported to HCFA; used by surveyors to generate quality indicators which flag the prevalence of health problems; used by nursing homes to develop care plans for each patient.
- Nursing facility – a nursing home, or portion thereof, that provides an intermediate level of medical care to the aged or disabled; the facility may receive Medicaid payments for patients meeting financial criteria
- Nursing Home – a residential facility providing nursing care and related services beyond the basic provision of food, shelter, and laundry; residents are admitted because of illness, disease, or physical infirmity; may be skilled nursing facility (SNF) or a nursing facility (NF).
- On-Line Survey, Certification, and Reporting System (OSCAR) --- the federal information system used to record the results of annual surveys, complaint investigations, and other facility information. This system is being replaced in phases by a more comprehensive and more easily accessed system. Full implementation of the new system is due in 2002.
- Plan of Correction – provider/supplier’s written plan to correct deficiencies, stating how corrective actions will be made and the completion date for correction.
- Pre-Admission Evaluation (PAE) – an instrument used by the Division of Long-Term Care within the Bureau of TennCare to determine the amount of Medicaid payment a nursing home will receive for a particular patient; level 1 approval indicates payment for intermediate nursing care and level 2 approval indicates payment for skilled nursing care.
- Skilled nursing facility – a nursing home, or portion thereof, that provides a higher level of nursing care to the aged or disabled; the facility may receive Medicare payments for patients needing convalescent or rehabilitative care upon exiting a hospital.
- Survey – a nursing facility inspection conducted on an annual schedule or to investigate a complaint made against a facility. Surveys can be limited in scope or can include the entire facility operation.

Appendix 4

Nursing Facility Ownership or Control

The following table was compiled by Comptroller's staff from information obtained by the Department of Health. Data was extracted from the OSCAR database on October 6, 2000, by the HCFA regional office in Atlanta. Most nursing facilities in the state (205) are owned by corporations and are operated for profit. Most non-profit facilities (57) are operated by corporations. Most government controlled facilities are operated by counties (26).

Type of Control	Number of Type
For Profit	68%
Individual	3
Partnership	33
Corporation	205
Non-Profit	22%
Church Related	17
Non-Profit Corporation	57
Other Non-Profit	4
Government	9%
State	2
County	26
City	2
City/County	3
Other	1%
Hospital District	2

Appendix 5

States with regulations that exceed federal minimum requirements

Thirty-five states, including Tennessee, have state minimum staffing standards that exceed the federal requirements. Federal regulations do not quantify staffing requirements, only calling for sufficient staff to ensure quality of care. The following table details each state's additional requirements.

State	Additional State Standard
Alaska	Greater licensed nurse coverage than federal standard
Arkansas	Staff ratios: CNAs – 1:7 Day; 1:12 Evening; 1:18 Night Licensed Personnel – 1:15 Day; 1:15 Evening; 1:35 Night
California	Skilled Nursing Facility - 3 hrs. per patient per day; Skilled Nursing Facility with special treatment program - 2.3 hrs. per patient per day; Nursing Facility - 1.1 hrs. per patient per day; Nursing Facility for developmentally disabled - 2.7 hrs. per patient per day
Colorado	2 hrs. per patient per day; facilities must have RN on duty at all times;
Connecticut	Chronic and Convalescent Home - 1.4 hrs. per patient from 7 a.m. – 9 p.m.; Rest Home with Nursing - 7 hrs. per patient from 7 a.m. – 9 p.m.; must be RN on duty at all times
Florida	1.7 hrs. per patient per day by CNAs; 0.6 hrs. per patient per day by licensed nursing staff
Georgia	2 hrs. per patient per day; 2.5 hrs. per patient per day in Level I and Level II Medicaid facilities
Hawaii	Skilled Nursing Facilities – full-time RN at all times; Intermediate Care Facilities – full-time RN on day shift and one licensed nurse whenever medications are given
Idaho	Skilled Nursing Facilities - 2.4 hrs. per patient per day; Nursing Facility – 1.8 hrs. per patient per day
Illinois	Skilled Nursing Facilities – 2.5 hrs. per patient per day (20 percent licensed nurse time); Immediate Care Facility – 1.7 hrs. per patient per day (20 percent licensed nurse time); Light Intermediate Care – 1 hr. per patient per day (20 percent licensed nurse time)
Indiana	0.5 licensed nurse hr. per patient per day
Iowa	Intermediate Care – 2 hrs. per patient per day (20 percent qualified nurses)
Kansas	2 hrs. per patient per day (weekly average); 1.8 hrs. per patient per day (daily average)
Louisiana	1.5 hrs. per patient per day; Ratio of 2:35 Medicaid beds; Ratio of 2:60 nursing care hours for skilled level residents
Maine	Ratio – 1:8 day shift; 1:12 evening shift; 1:20 night shift
Maryland	2 hrs. per patient per day
Massachusetts	Level I - 2.6 hrs. per patient per day (0.6 licensed nurse time and 2 ancillary nurse time); Level II – 2 hrs. per patient per day (0.6 licensed nurse time and 1.4 ancillary nurse time)

Michigan	2.25 hrs. per patient per day
Minnesota	2 hrs. per patient per day
Mississippi	2.33 hrs. per patient per day
Montana	Hrs. per patient per day based on licensed beds and staff hours
Nevada	Skilled Nursing Level 3 – 6 hrs. per patient per day; Skilled Nursing Level 2 – 4 hrs. per patient per day; Skilled Nursing Level 1 – 2 hrs. per patient per day; Intermediate Care Level 3 – 2.5 hrs. per patient per day; Intermediate Care Level 2 – 1.5 hrs. per patient per day; Intermediate Care Level 1 - 0.75 hrs. per patient per day
New Jersey	2.5 hrs. per patient per day
North Carolina	2.1 hrs. per patient per day
Ohio	Ratio of 1:15 plus one other person; at least one person working 40 hrs./week for each 4 residents; at least 1 nurse for each 50 residents
Oklahoma	Ratio of 1:10 on day shift; 1:15 on evening shift; 1:20 on night shift
Oregon	Ratio of 1:10 on day shift; 1:15 on evening shift; 1:25 on night shift
Pennsylvania	Skilled care patients – 2.7 hrs. per patient per day; Intermediate care patients – 2.3 hrs. per patient per day
South Carolina	Ratio of 1:9 on day shift; 1:13 on evening shift; 1:22 on night shift
Tennessee	2 hrs. per patient per day; includes .4 hrs. per patient per day by licensed nursing personnel
Texas	0.4 hrs. per patient per day of licensed nursing care
Washington	Skilled care – 2.25 hrs. per patient per day; Intermediate care – 2 hrs. per patient per day; 20 percent of hrs. per patient per day must be provided by nurses
West Virginia	2 hrs. per patient per day; includes 0.4 hrs. per patient per day by licensed nursing personnel
Wisconsin	Intensive Skilled Nursing Facility – 3.25 hrs. per patient per day (0.65 by RN or LPN); Skilled Nursing Facility – 2.5 hrs. per patient per day (0.5 by RN or LPN); Intermediate – 2 hrs. per patient per day (0.4 by RN or LPN)
Wyoming	Skilled Nursing Facilities – 2.25 hrs. per patient per day; Nursing Facilities – 1.5 hrs. per patient per day

Source: National Citizens' Coalition for Nursing Home Reform, Oct. 1999.

Appendix 6

Nursing Home Initiative: HCFA's Implementation Chronology

August 1998	Revised revisit policy by requiring states to actually visit nursing homes to ensure serious deficiencies have been corrected and that facilities have returned to compliance.
September 1998	HCFA eliminated the grace period for homes with repeated serious violations. States are required to refer such homes to HCFA for immediate sanctions.
October 1998	Standard protocols were issued for observational surveys and the number of comparative surveys was increased. HCFA now requires a minimum of one comparative survey in states having fewer than 200 nursing homes, two in states with 200 to 599 nursing homes, and three in states with 600 or more homes. Ninety percent of federal monitoring surveys will continue to be observational.
January 1999	State survey agencies are required to initiate 10 percent of annual surveys outside normal work hours.
January 1999	State survey agencies are instructed to begin enhanced monitoring of two nursing homes per state – facilities with histories of providing poor care.
March 1999	State survey agencies are to begin investigating complaints that allege actual harm by conducting an on-site visit within ten days.
May 1999	States are allowed to impose per-instance civil monetary penalties when a period of noncompliance is unclear or in other appropriate circumstances. States may not impose both a per-instance and per-day fine for the same survey.
May 1999	For FY1999 and FY2000, the Health and Human Services Appeals Board received funding to hire more personnel to help reduce the backlog of nursing home appeals.
July 1999	HCFA instructed states to incorporate quality indicators into the survey process. Quality indicators are derived from nursing homes' assessments of residents and rank a facility in 24 areas with other nursing homes in the state. By using the quality indicators to select a preliminary sample of residents before the survey begins, surveyors are better prepared to identify potential care problems. Concurrently, HCFA published new investigative protocols for use

by surveyors on key issues such as abuse prevention, pressure sores, dehydration, and unexplained weight loss.

December 1999	States are instructed to ensure adequate reasonable assurance period for terminated homes seeking readmission to Medicare. Typically, two surveys are required within this period to verify that the reason for termination no longer exists and that the provider has maintained substantial compliance with all applicable participation requirements.
December 1999	States are instructed to consider a nursing home's pre-termination history when taking enforcement actions after a home has been readmitted.
December 1999	HCFA eliminated the grace period for homes with repeated serious violations. States are required to recommend these homes to HCFA for immediate sanctions.
Projected Late 2000	HCFA is proposing new instructions requiring states to deny a grace period for facilities with performance problems that are part of a chain consisting of over 100 homes.
Projected Summer 2001	HCFA's computer system is being re-designed to require less computer programming experience to conduct data analysis.
Projected 2002 or 2003	HCFA plans to improve the method for selecting samples for surveys and ensure that surveyors are more rigorous in their on-site surveys.

Source: GAO/HEHS-00-197, Nursing Homes: Sustained Efforts Are Essential to Realize Potential of the Quality Initiatives, September 2000.

Appendix 7

Suggested Minimum Field List for Facility Report

This is intended as a minimum list, to which the department should add fields necessary to serve the purpose of an annual facility report.

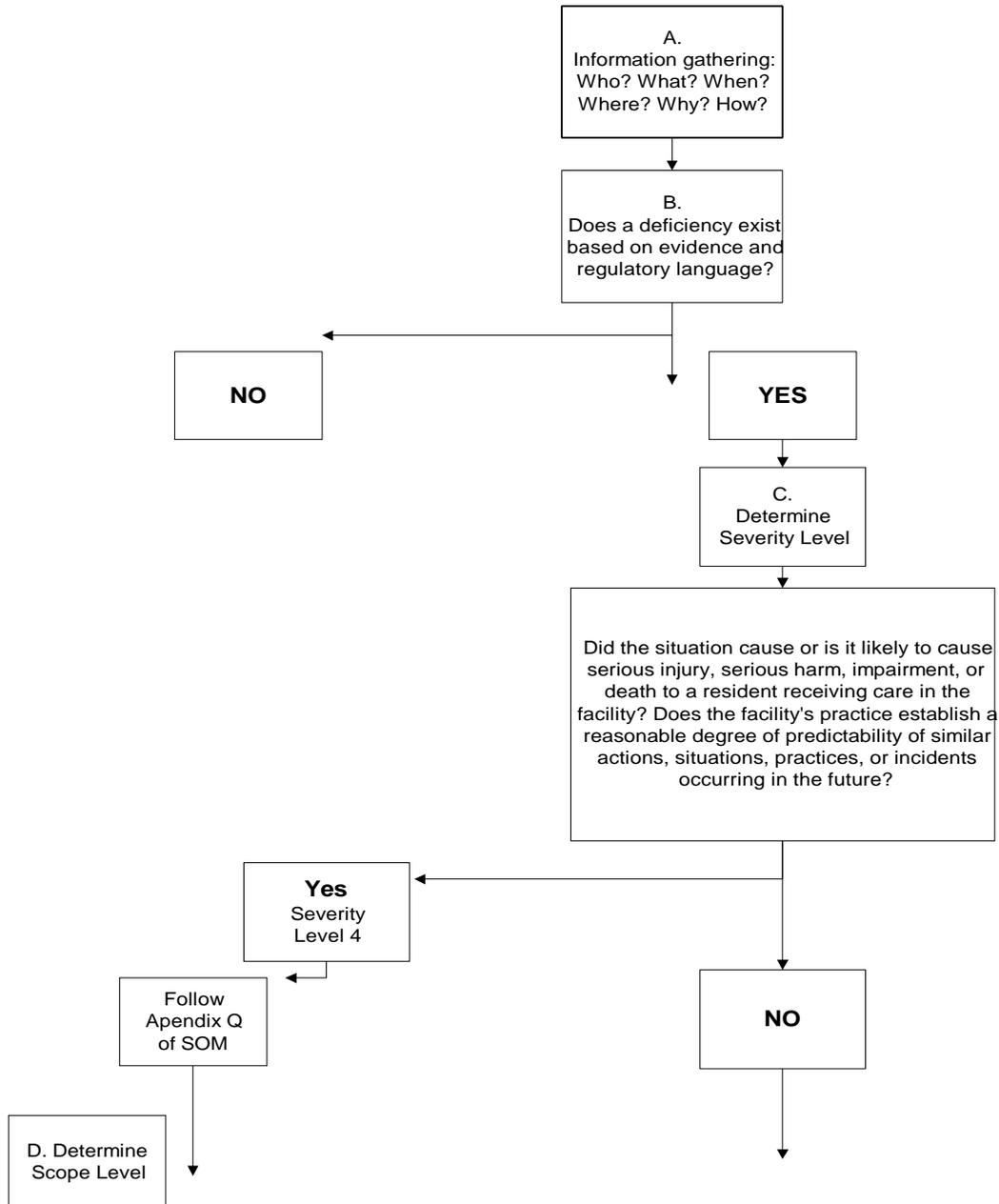
- **facility index number** [unique identifier]
- **region** [This is problematic for analysis. However, it should be included since the department is organized administratively by region.]
- **fiscal year** [This should be a standard date field and should correspond throughout the records in the database. The state fiscal year should be used. This field will be used for year-to-year comparison; therefore it is not necessarily the fiscal year of the facility.]
- **type of control**
[e.g., corporate, proprietorship, etc.; there are various listings in the HCFA database]
- **tax status**
for profit
not for profit
- **dollar amount of reimbursement**
state
federal
other
- **dollar amount of taxes paid**
local
state
federal
- **number of facility beds**
number of skilled beds
number of intermediate beds
- **number of personnel [fte]**
number of administrative personnel
number of registered nurses
number of licensed practical nurses
number of licensed physical therapists
number of licensed occupational therapists
number of other licensed personnel
number of certified nurse technicians
number of other certified personnel
number of other personnel [e.g., physical therapist aides]
- **personnel costs**
average wage costs for each position type
average benefit costs for each position type
- **survey date** [most recent]

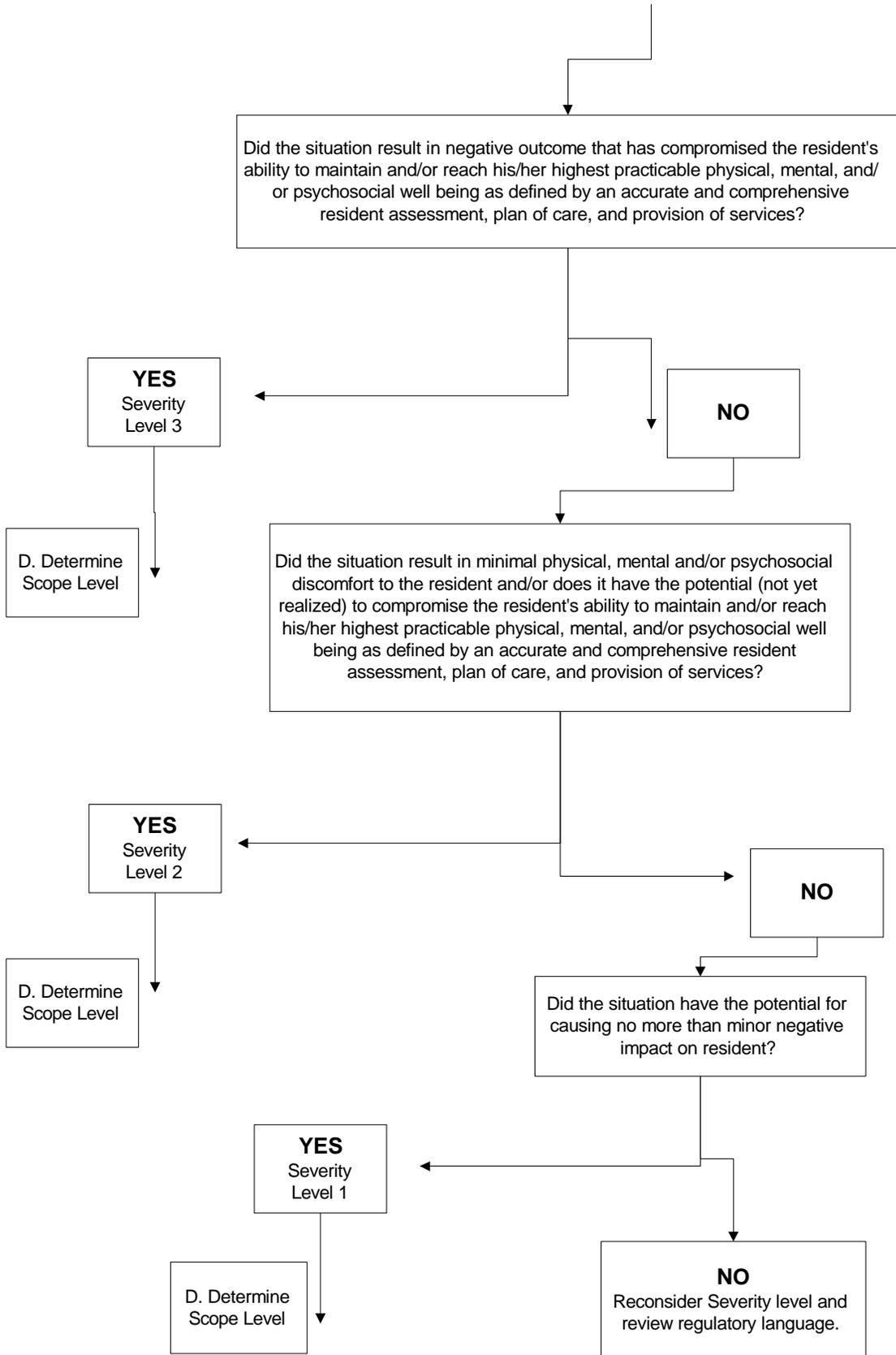
- **number of deficiencies**
number of deficiencies by tag number
- **number of penalties assessed**
number of each type of penalty
- **dollar amount of penalties assessed**
- **dollar amount of penalties under appeal**
- **dollar amount of penalties paid**
- **number of complaints**
number of self-reported complaints
number of complaints from other sources
- **number of founded complaints**
number of founded self-reported complaints
number of founded complaints from other sources

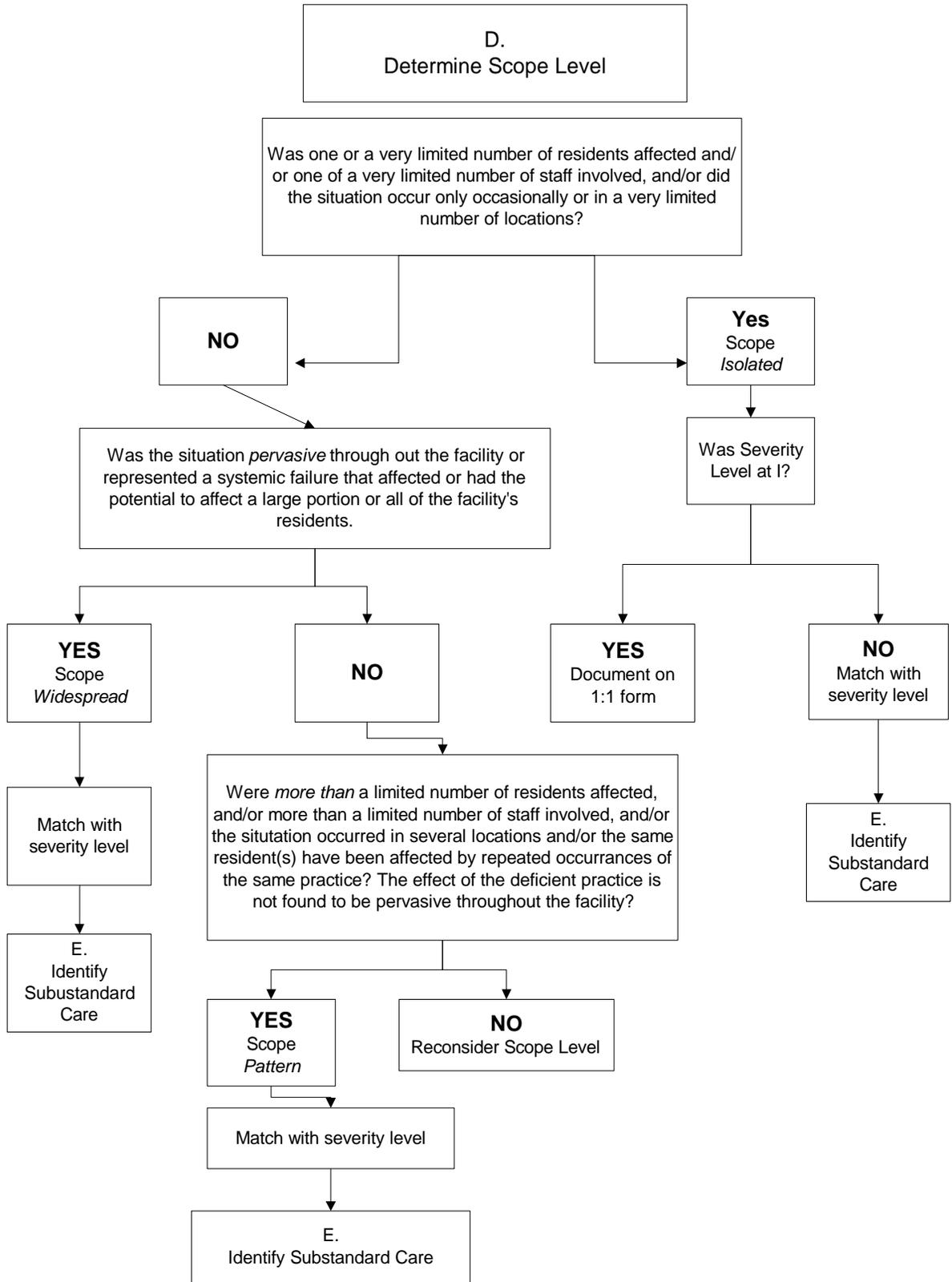
Appendix 8

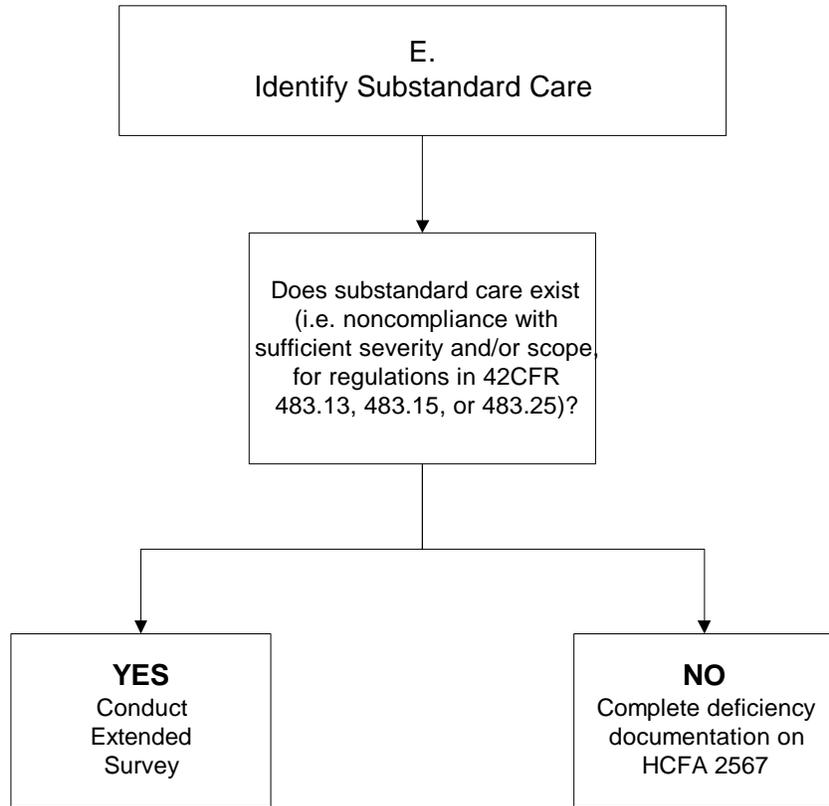
Decision Making Process Map

Decision Making Process Map









Source: Appendix P, State Operations Manual, HCFA

Appendix 9

Criteria for Medicaid-reimbursed Levels One and Two

In order to be approved for Medicaid-reimbursed Level 1 care, the nursing facility resident must meet financial qualifications as well as both of the following criteria:

1. **Medical Necessity of Care:** Care in a Nursing Facility must be expected to improve or ameliorate the individual's physical or mental condition, to prevent a deterioration in health status, or to delay progression of a disease or disability, and such care must be ordered and supervised by a physician on an ongoing basis.
2. **Need for Inpatient Nursing Care:** The individual must have a physical or mental condition, disability, or impairment that, as a practical matter, requires daily inpatient nursing care. The individual must be unable to self-perform needed nursing care and must meet or equal one or more of the following criteria on an ongoing basis:
 - (a) **Transfer** – the individual is incapable of transfer to and from bed, chair, or toilet unless physical assistance is provided by others on an ongoing basis. (daily or multiple times per week.)
 - (b) **Mobility** – The individual requires physical assistance from another person for mobility on an ongoing basis (daily or multiple times per week). Mobility is defined as the ability to walk, using mobility aids such as a walker, crutch, or cane if required, or the ability to use a wheelchair if walking is not feasible. The need for a wheelchair, walker, crutch, cane, or other mobility aid shall not by itself be considered to meet this requirement.
 - (c) **Eating** – The individual requires gastronomy tube feedings or physical assistance from another person to place food/drink into the mouth. Food preparation, tray set-up, and assistance in cutting up foods shall not be considered to meet this requirement.
 - (d) **Toileting** – The individual requires physical assistance from another person to use the toilet or to perform incontinence care, ostomy care, or indwelling catheter care on an ongoing basis (daily or multiple times per week).
 - (e) **Expressive and Receptive Communication** – The individual is incapable of reliably communicating basis needs and wants (e.g., need for assistance with toileting; presence of pain) using verbal or written language; or the individual is incapable of understanding and following very simple instructions and commands (e.g., how to perform or complete basic activities of daily living such as dressing or bathing) without continual staff intervention.
 - (f) **Orientation** – The individual is disoriented to person (e.g., fails to remember own name, or recognize immediate family members) or is disoriented to place (e.g., does not know residence is Nursing Facility).
 - (g) **Medication Administration** – The individual is not mentally or physically capable of self-administering prescribed medications despite the availability of limited assistance from another person. Limited assistance

includes, but is not limited to, reminding when to take medications, encouragement to take, reading medication labels, opening bottles, handing to individual, and reassurance of the correct dose.

- (h) Behavior – The individual requires persistent staff intervention due to an established and persistent pattern of dementia-related behavioral problems (e.g., aggressive physical behavior, disrobing, or repetitive elopement).
- (i) Skilled Nursing or Rehabilitative Services – The individual requires daily skilled nursing or rehabilitative services at a greater frequency, duration, or intensity than, for practical purposes, would be provided through a daily home health visit.

To be approved for Medicaid-reimbursed Level 2 care, the resident must meet financial qualifications as well as both of the following criteria:

1. Medical Necessity of Care: Care in a Nursing Facility must be expected to improve or ameliorate the individual's physical or mental condition, to prevent a deterioration in health status, or to delay progression of a disease or disability, and such care must be ordered and supervised by a physician on an ongoing basis.
2. Need for Inpatient Skilled Nursing or Rehabilitative Services on a Daily Basis: The individual must have a physical or mental condition, disability, or impairment that requires skilled nursing or rehabilitative services on a daily basis or skilled rehabilitative services at least five days per week when skilled rehabilitative services constitute the primary basis for the approval of the PreAdmission Evaluation. The individual must require such services at a greater frequency, duration, or intensity than, for practical purposes, would be provided through a daily home health visit. In addition, the individual must require skilled services which, in accordance with accepted medical practice, are not usually and customarily self-performed.⁵⁷

⁵⁷ Rules of the Tennessee Department of Health, Chapter 1200-13-1.