

NURSING FACILITIES' SELF-REGULATION CANNOT REPLACE INDEPENDENT SURVEYS: A STUDY OF SPECIAL FOCUS FACILITIES, THEIR HEALTH SURVEYS, AND THEIR SELF-REPORTED STAFFING AND QUALITY MEASURES

INTRODUCTION

The Centers for Medicare & Medicaid Services (CMS) identifies nursing facilities that are among the facilities providing the poorest care to their residents. These facilities, called Special Focus Facilities (SFFs), receive special attention from the survey agency – at least two surveys each year and enhanced enforcement activities. While SFFs may not necessarily be the very poorest quality facilities in the country, they are certainly among the very poorest quality facilities.

The Center for Medicare Advocacy (the Center) evaluated Special Focus Facilities (SFFs) on the list released by CMS on May 16, 2011. The Center compared the star ratings for a sample of SFFs, evaluating the ratings for health surveys (independent outside reviews), staffing (self-reported), quality measures (self-reported), and composite ratings. The Center hypothesized that SFFs would report high levels of staffing and high quality measures, particularly in the highly suspect quality measure of pain.

The hypothesis was proven by the data. SFFs, which have very low health survey results, nevertheless report high staffing levels and high quality measures. The Center concludes that facilities' self-reported staffing and quality measure data cannot be relied on to provide an accurate picture of a nursing facility. This conclusion refutes the nursing home industry's claim that facilities can effectively regulate themselves.¹

CMS'S SPECIAL FOCUS FACILITY PROGRAM

Each month, CMS identifies SFFs from among the most poorly performing facilities in the country, based on its analysis of survey deficiencies cited in the prior three years. CMS gives a list of candidate facilities to each state survey agency, which then makes recommendations to CMS. The final selection of SFFs is made by CMS. State survey agencies conduct at least two standard health surveys in each SFF each year. SFFs are identified on *Nursing Home Compare* as SFFs and are subject to enhanced enforcement. SFFs are expected to improve ("graduate") within 18-24 months. If they do not improve or show signs of being close to improved, SFF guidance indicates that they should be terminated from participation in the Medicare and Medicaid programs.

A detailed history of the SFF program appears in Appendix 1.

METHODOLOGY OF THE STUDY

The Center based its evaluation on the SFF list that was released by CMS on May 16, 2011. The list includes five categories of 191 SFFs:

- Table A: Facilities Newly Added to the SFF Program (22 facilities)
- Table B: Facilities That Have Not Improved (66 facilities)
- Table C: Facilities That Have Shown Improvement (56 facilities)
- Table D: Facilities That Have Recently Graduated from the SFF Program (45 facilities)
- Table E: Facilities No Longer Participating in the Medicare and Medicaid Program (2 facilities)

The Center printed the information from *Nursing Home Compare* on June 14, 2011 for all 22 facilities in Table A (newly-added SFFs) and 20% of facilities listed in Tables B (14 facilities) and C (11 facilities) – a total of 47 of the 144 facilities (33%) that are currently identified as SFFs.

The Center analyzed the star ratings for each of the three categories of information publicly reported on *Nursing Home Compare*: health survey results, staffing, and quality measures. While all three data sources have some problems, the self-reported data (staffing and quality measures) are the most problematic.

Health survey data

Nursing facilities that participate in the Medicare or Medicaid programs, or both, have an unannounced survey each year. Surveys are conducted by state survey agencies, usually located in the state department of health, using a survey protocol that has been developed, tested, and validated by the federal government.²

The Government Accountability Office (GAO) has issued many reports over the past 13 years describing the enforcement system as underciting deficiencies and undercoding the significance (scope and severity) of deficiencies it identifies.³ State survey reports often give a far more positive description of facilities than actually justified. Nevertheless, the publicly-conducted survey is the only objective, independent evaluation of the quality of care provided by nursing facilities.

Staffing data

Staffing information reported on *Nursing Home Compare* reflects data provided by facilities to surveyors at the time of survey. Facilities complete a CMS form reporting staffing information from the two weeks preceding the survey. CMS does not audit the self-reported information.

Staffing data reported on *Nursing Home Compare* are frequently criticized as inaccurate and as overstating actual staffing levels.⁴ More than a decade ago, the comprehensive nurse staffing report written by the Health Care Financing Administration (HCFA), CMS's predecessor agency, identified problems in the staffing data reported in the Online Survey Certification and Reporting (OSCAR) system.⁵ The Second Phase of that report, issued in 2001, described the accuracy of nurse staffing information for individual facilities, as reported in OSCAR, as "unacceptable."⁶

In 2005, CMS implemented a set of exclusion rules for suspect nurse staffing data, recognizing that staffing data reported on *Nursing Home Compare* have limitations because they are derived from OSCAR, which was not designed for the public reporting use. CMS announced that if staffing ratios "fall above or below certain thresholds or exhibit a very rare configuration, the data are viewed as suspect and will be temporarily excluded from NHC until they are corrected or confirmed."⁷

The reporting of nurse staffing levels is expected to change soon. The Affordable Care Act requires that *Nursing Home Compare* report staffing data that are based on "payroll and other verifiable and auditable data in a uniform format" and electronically submitted to CMS.⁸ Although the statutory provision becomes effective in 2012, CMS recently announced that it was delaying implementation, due to anticipated cuts of 10-12% in the federal survey and certification budget for the current fiscal year.⁹

Quality measures

Like staffing levels, quality measures are self-reported by facilities. Quality measures reflect resident characteristics and care needs, as identified in the resident assessments. Federal law requires facilities to conduct comprehensive assessments of each resident's needs annually, using multidisciplinary teams. Assessments are updated quarterly, with additional assessments conducted whenever a resident experiences a significant change.¹⁰ Facilities must use these assessments to develop individualized, comprehensive care plans for residents.¹¹

Since 2002, CMS has publicly reported resident assessment information as quality measures. This use reflects a significant change from the original purpose of the measures.

Under contract with CMS, the University of Wisconsin developed “quality indicators” in order to help surveyors focus their limited time on-site at facilities on care issues that seemed more likely to indicate deficiencies. In surveyor training, the contractors stressed that quality indicators did not mean that facilities provided good or poor care; they were simply “indicators” of issues that surveyors needed to investigate during the survey. In the Fall of 2002, however, the Bush Administration proposed publishing the quality indicators on CMS’s website *Nursing Home Compare*. In November 2002, the GAO recommended delaying public reporting of quality indicators until “there is greater assurance that quality indicators are appropriate and based on accurate data.”¹² CMS ignored the recommendation and went forward with publishing quality measures on the *Nursing Home Compare* website, renaming them quality measures or performance measures.

This study also evaluated two of the four clinical measures used by the nursing home industry’s *Advancing Excellence* campaign – pain in short-term and long-term residents. Of the 15 measures currently reported on *Nursing Home Compare*, pain is an especially suspect measure, as numerous analyses have repeatedly documented:

- Nursing facilities report considerably lower rates of pain than independent researchers consider valid and true.¹³
- CMS’s Data Assessment and Verification (DAVE) project, which was designed to help facilities conduct more accurate resident assessments, found that facilities had the highest discrepancy rates in their assessments of medications and pain.¹⁴
- CMS’s quality-based purchasing demonstration explicitly chose not to use either of the publicly-reported pain measures “because of concerns about differences across nursing homes in how they assess pain.”¹⁵ The demonstration noted that previous studies “found that the [Minimum Data Set] (MDS) underreports pain in cognitively impaired residents.”¹⁶
- A major change in the resident assessment instrument, the MDS 3.0, which was implemented October 1, 2010, is the determination of resident pain. Resident interviews replaced staff observations; MDS 2.0 had “repeatedly shown to have poor correspondence with independent pain assessments.”¹⁷
- A recent article suggests that facilities downcoded residents’ pain, following the public reporting of pain measures.¹⁸

Five Star Rating System

In December 2008, CMS created a new five-star rating system for nursing facilities and posted the ratings on *Nursing Home Compare*.¹⁹ Each facility participating in Medicare or Medicaid, or both, receives a rating of one to five stars on each of three dimensions (health survey, staffing, and quality measures), a composite rating that combines all three dimensions, and a separate rating for registered nurse (RN) staffing.

The stars reflect the following meanings:

- ***** Much above average
- **** Above average
- *** Average
- ** Below average

* Much below average

The history of the star rating program is described in additional detail in Appendix 2.

Health inspections

The health survey rating reflects performance on the three most recent annual health surveys that are conducted by state survey agencies. More recent surveys are weighted more heavily. The health inspection rating also includes deficiencies that are cited as a result of all complaint health inspections for the previous three years. The number of deficiencies as well as their scope and severity are used to calculate the star ratings.

Facilities are measured against other facilities in the same state. Deficiencies identified in federal oversight surveys and Life Safety Code deficiencies are not used to calculate facility ratings.

Facilities with fewer total deficiencies, fewer serious deficiencies, and fewer revisits, compared to other facilities in their state, receive higher star ratings. The top 10% of facilities in a state receive five stars; the bottom 20%, one star; and the middle 70%, two, three, or four stars (23.33% each).

Staffing

The staffing rating calculates the number of hours of care by licensed nursing staff (RN, LPN/LVN) and certified nurse assistant (CNA)), as self-reported by facilities and as adjusted by the facility's case-mix. The RN measure includes Directors of Nursing and other RNs with administrative responsibilities. Facilities are measured against all facilities in the country.

Staffing is not reported separately for hospital-based and freestanding facilities in the star ratings portion of *Nursing Home Compare*, although the staffing portion of the website distinguishes staffing levels reported by hospital-based and freestanding facilities. Hospital-based facilities have significantly higher staffing levels than free-standing facilities.

A five-star staffing rating is limited to facilities that report that they meet the staffing standard identified by CMS in its 2002 nurse staffing report, as case-mix adjusted – 4.08 nursing hours per resident per day and .55 RN hours per resident per day.²⁰ A four-star staffing rating is given to facilities reporting compliance with one of the two 2002 standards, as case-mix adjusted.

Quality measures

Ten quality measures (QMs) (of the 19 reported on *Nursing Home Compare*), also self-reported by facilities, are used to create a QM score. Seven measures reflect long-stay residents and three, short-stay measures.

Long-stay prevalence measures

- (Activities of Daily Living) ADL change
- Mobility change
- High-risk pressure ulcers
- Long-term catheters
- Physical restraints
- Urinary tract infection
- Pain

Short-stay prevalence measures

Delirium
Pain
Pressure ulcers

The two ADL measures (ADL change and mobility change), which account for 40% of the total QM score, are based on comparisons to other facilities in the state for the three most recent quarters. The remaining eight measures, 60% of the QM score, use national data for comparisons.

Composite ratings

To create a composite score for each facility, the rating system begins with the number of stars resulting from health inspections. Staffing, whose rating is applied next, can only affect a facility’s rating at the upper and lower extremes. A five-star staffing rating increases a facility’s composite rating by one star; a four-star staffing rating increases a facility’s composite score by one star if the survey rating is one, two, or three stars; a one-star staffing rating decreases a facility’s composite rating by one star. Staffing ratings of two or three stars do not change the composite score.

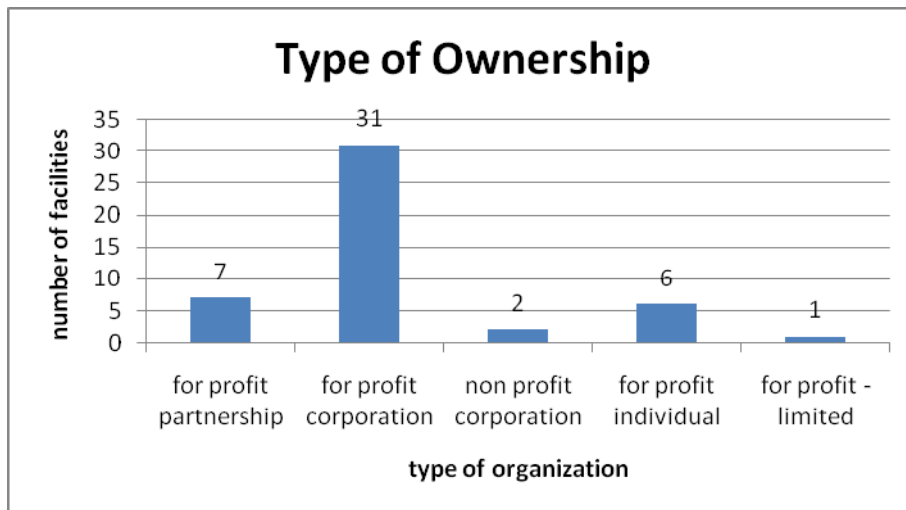
Scores on quality measures are applied last, again affecting a facility’s rating only at the extremes. A five-star QM rating increases a facility’s composite rating by one star; a one-star QM rating decreases a facility’s composite rating by one star.

A Special Focus Facility cannot receive more than three stars.

FINDINGS

Who owns the Special Focus Facilities?

The overwhelming majority of SFFs (45 of 47 facilities, or 96%) are owned on a for-profit basis.



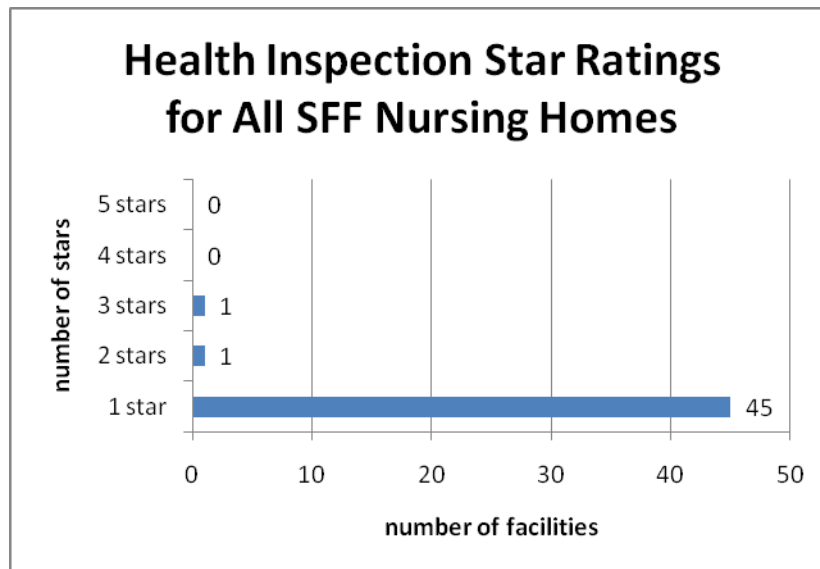
How do SFFS look on *Nursing Home Compare*?

All SFFs had low star ratings on health surveys (as expected, since the primary method of identifying SFFs relies on health surveys). However, SFFs reported considerably higher nurse staffing and quality measures, resulting in higher star ratings on those two domains than on the health survey domain.

The following tables report information for all 47 SFFs evaluated. Additional tables, separately describing newly-added SFFs, SFFs not showing improvement, and SFFs showing improvement, are included in Appendix 2.

Health Inspections

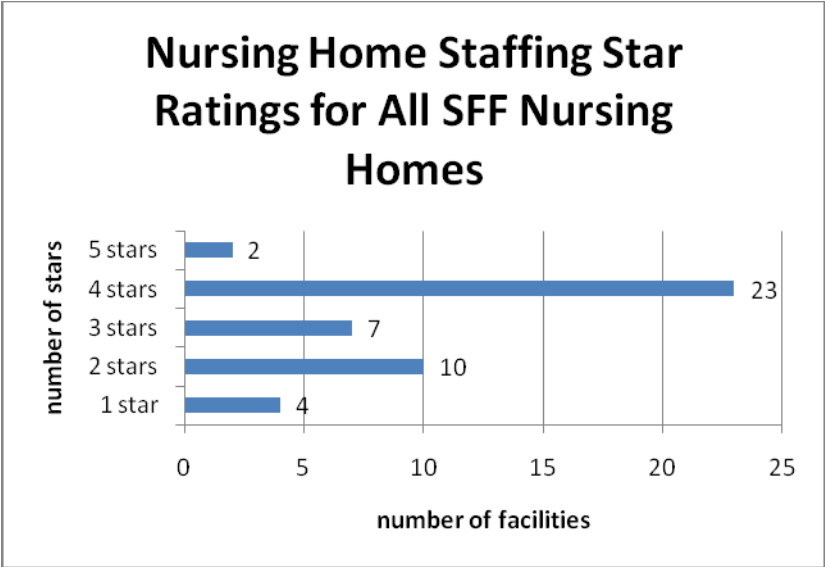
Most SFFs (newly-added, no improvement, and shown improvement), (45 of 47, or 96%) had one star in health inspections. One of 47 facilities (2%), a facility that had not shown improvement, had two stars. One of 47 facilities (2%), a facility that had shown improvement, had three stars.



Staffing

All facilities also reported staffing levels that led to the assignment of star ratings considerably higher than those for their health surveys. Thirty-two of 46 facilities (70%) reported staffing levels that led to star ratings of three or more stars.

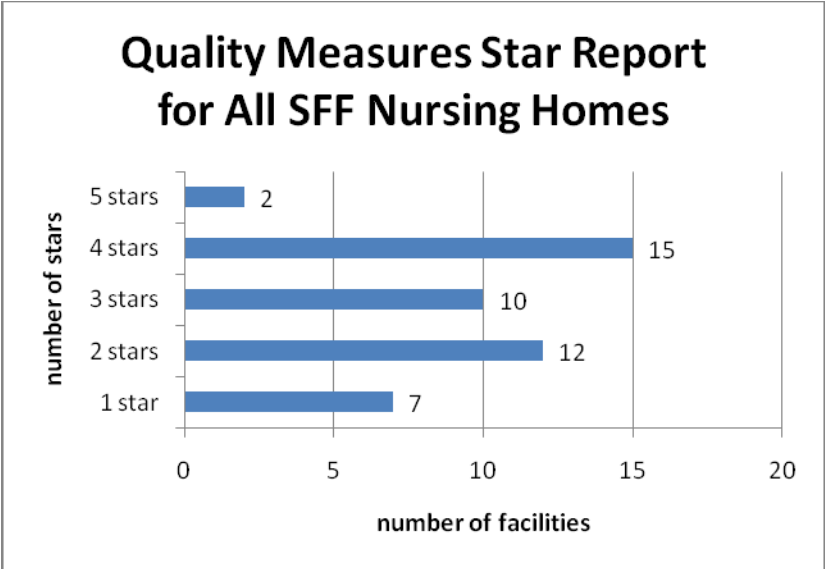
More than half (25 of 46 facilities, 54%) reported staffing levels that led to four- and five-star staffing ratings. Seven of 46 facilities (15%) reported staffing levels that led to three-star staffing ratings. Only 14 of 46 facilities (30%) reported staffing levels that led to one- and two-star ratings in staffing. Note: Staffing was not reported for one of the newly-added SFFs.



Quality measures

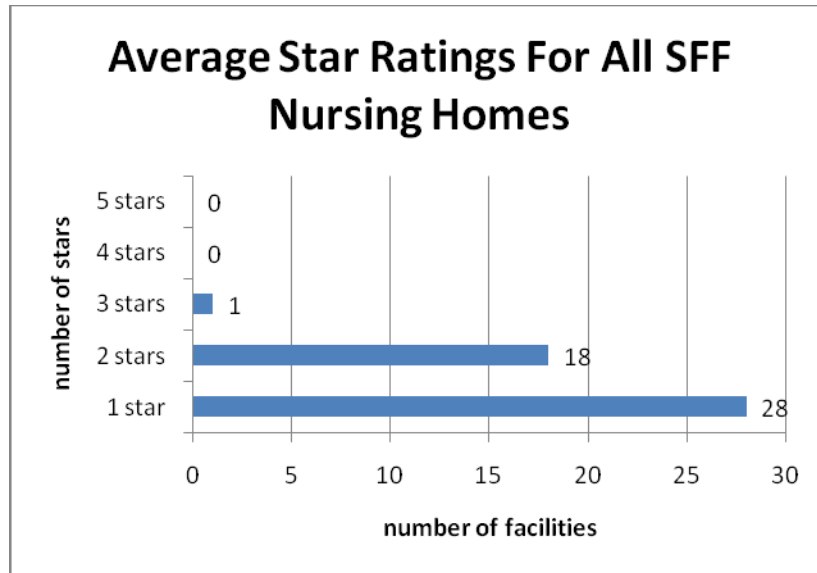
Star ratings for quality measures for all SFFs were also considerably higher than health survey ratings. More than half the facilities (27 of 47 facilities, or 57%) reported quality measures that led to star ratings of three or above.

More than a third of the facilities (17 of 47 facilities, 36%) reported quality measures that led to four- and five-star ratings. Ten of 47 facilities (21%) reported quality measures that led to three-star ratings. Only 19 of 47 facilities (40%) reported quality measures that led to one- and two-star ratings.



Composite scores

The composite ratings for all SFFs reflect the higher star ratings for staffing and quality measures. One of 47 facilities (2%) received three stars; 18 facilities (38%) received two stars; and 28 facilities (60%) received one star.

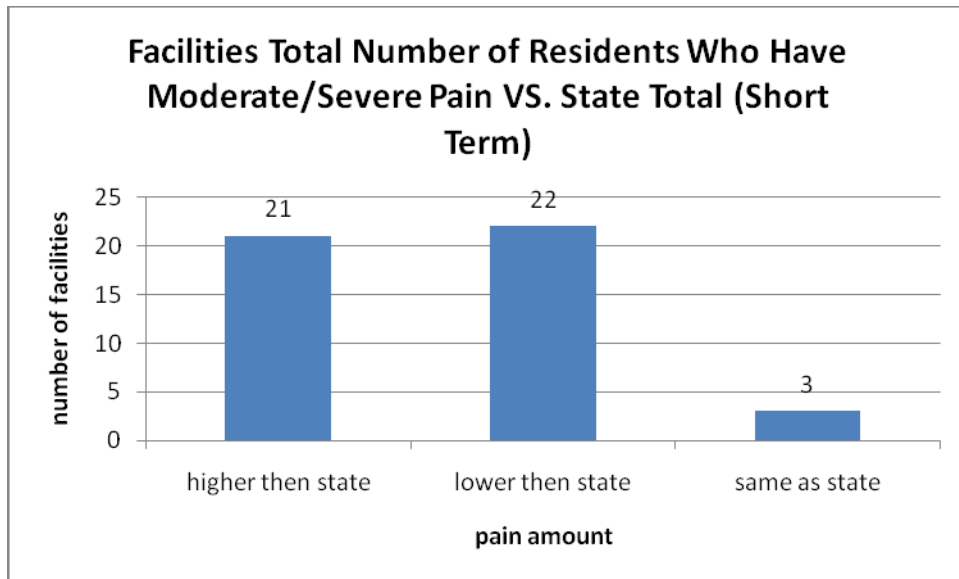


The quality measure pain

Pain is reported separately for post-acute (or short-stay) residents (defined as those with a 14-day PPS MDS (prospective payment system minimum data set) in the 2 consecutive target quarters)²¹ and for chronic (or long-stay) residents (defined as those who have a full or quarterly MDS in the target quarter).²²

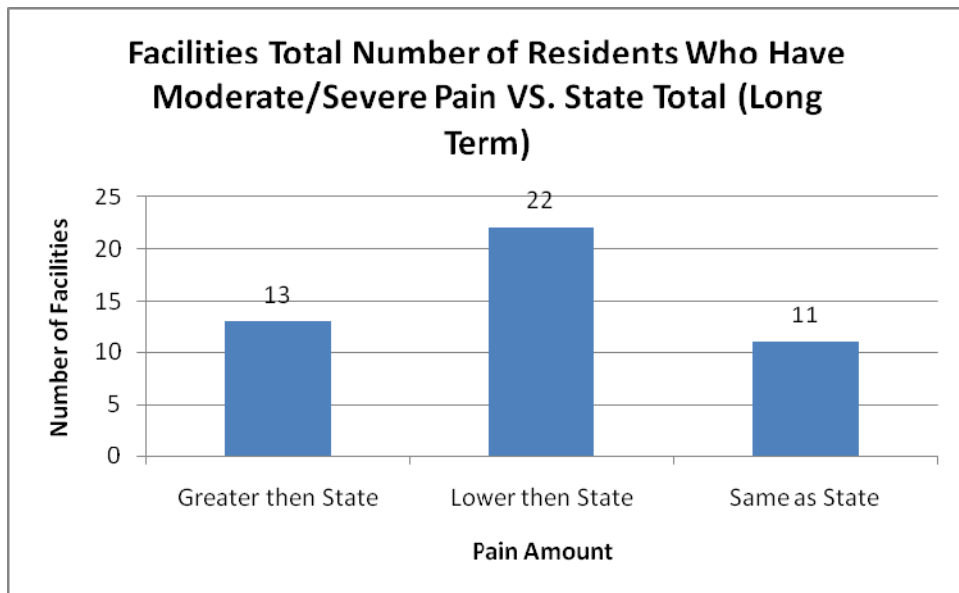
Post acute (or short-stay) residents

Of the 46 facilities that reported pain for their short-term residents, 22 facilities (48%) reported lower pain rates than the statewide average for their state; 21 facilities (46%) reported higher pain rates than the statewide average for their state; and three facilities (6%) reported the same pain rate as the statewide average for their state.



Chronic (or long-stay) residents

Of the 46 facilities that reported pain for their long-term residents, nearly half (22 of 46 facilities, 48%) reported lower pain rates than the statewide average for their state; 13 of 46 facilities (28%) reported higher pain rates than the statewide average for their state; and 11 facilities (24%) reported the same pain rate as the statewide average for their state.



DISCUSSION

The Center hypothesized that SFFs would report high levels of staffing and high quality measures, particularly in the highly suspect quality measure of pain. This hypothesis was proven by the data. Facilities identified by CMS as SFFs nevertheless frequently report high staffing levels and high resident assessment data (leading to high quality measures). The lack of correlation between survey data and SFFs’ self-reported staffing levels and

quality measures, combined with research showing that facilities' self-reported staffing data are unreliable, make their self-reported data highly suspect.

This study evaluated only SFFs. It did not evaluate whether non-SFF facilities similarly over-state their staffing levels and quality measures. Nevertheless, the study calls into question the public reporting of all facilities' unaudited staffing and quality measure data.

Moreover, the implications of these findings may be significant as proposals are offered in Congress and at CMS to "streamline" the survey process. Proposals using facilities' self-reported staffing and quality measures to identify facilities that can have a less intense annual survey or a less-than-annual survey are suspect and should be rejected.

The nursing home industry has been supporting revisions to the federal survey process for many years.

In July 2010, then-retiring Congressman Bart Stupak introduced "Enhancing Quality through Survey System Improvements Act of 2010," H.R. 6074, which would, among other changes to the survey process, eliminate annual surveys for "top tier" facilities (defined by the Secretary).²³ The American Health Care Association, the trade association of for-profit nursing facilities, published an Issue Brief on July 1, 2011 that recommends re-introduction of the bill.²⁴

Describing the federal survey and enforcement system as "broken and beyond repair," a Task Force convened by the American Association of Homes and Services for the Aging (AAHSA, the trade association of not-for-profit facilities, now known as Leading Age) calls for "a broad-based, national effort that will take a completely new look at the entire survey process and boldly redesign that system so that it supports and facilitates the original vision on which it was based."²⁵ AAHSA wants "a new oversight model."²⁶ The Task Force calls for a change in the federal law to "allow more flexibility in sequence, timing and/or intensity of nursing home surveys."²⁷

RECOMMENDATIONS

In light of SFFs' over-reporting of their staffing levels and quality measures, we recommend that

- Staffing and quality measures not be reported on *Nursing Home Compare* for any SFFs;
- No SFF be given more than one star on their composite scores unless and until it graduates from the SFF program;
- Pain not be used as a quality measure for *any* facility on *Nursing Home Compare*.

In addition, we recommend that any proposal to revise the federal survey process by reducing public oversight of facilities that self-report high staffing levels and high quality measures be rejected.

CONCLUSION

The nursing home industry has long sought to weaken the federal survey process, pointing to improving scores on quality measures as evidence that care in nursing homes is getting better. The Center's study shows that SFFs often report high staffing and high quality measures, despite their extremely poor performance on publicly-conducted, objective surveys. The study did not evaluate whether all other nursing facilities' self-reported staffing levels and quality measures are similarly inconsistent with their survey results. Nevertheless,

the study suggests, first, that consumers need to evaluate information about facilities critically and carefully, and second, that proposals to reduce survey time, based on facilities' self-reported quality measures and staffing levels, are suspect and should be rejected.

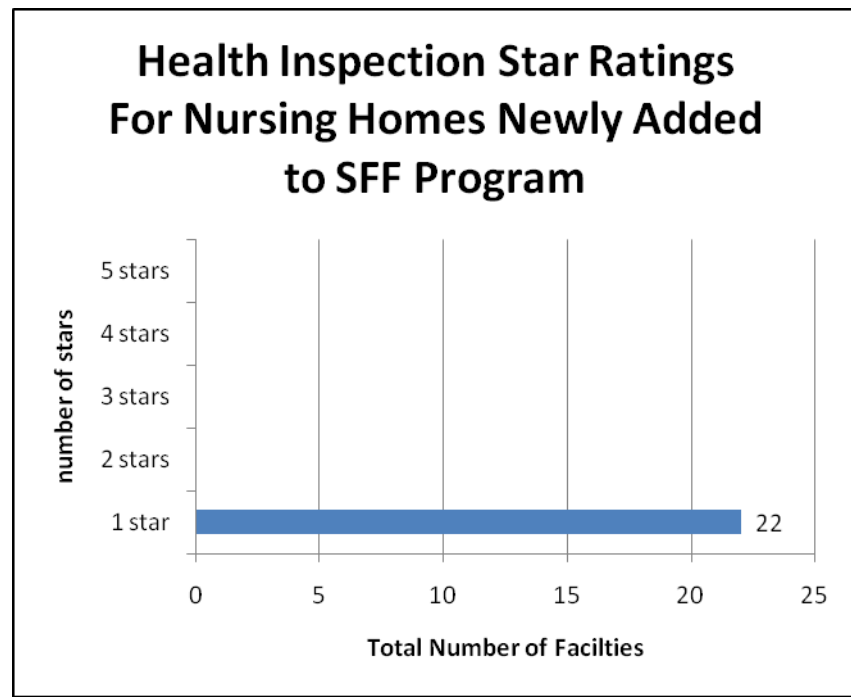
Appendices

Appendix 1

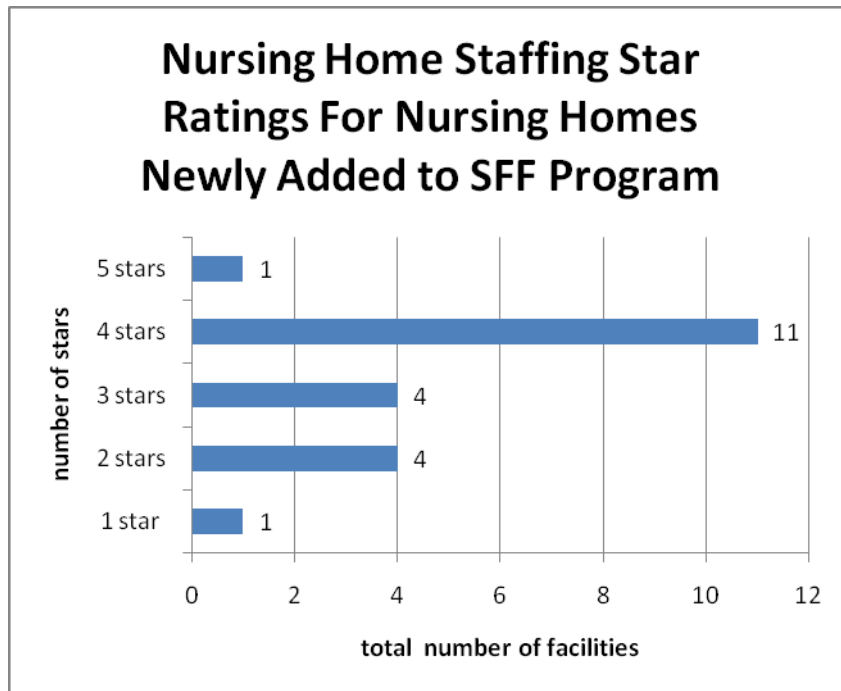
This appendix evaluates the 47 SFFs studied by separate category – newly added, now shown improvement, shown improvement.

Newly added SFFs (22 facilities, Table A):

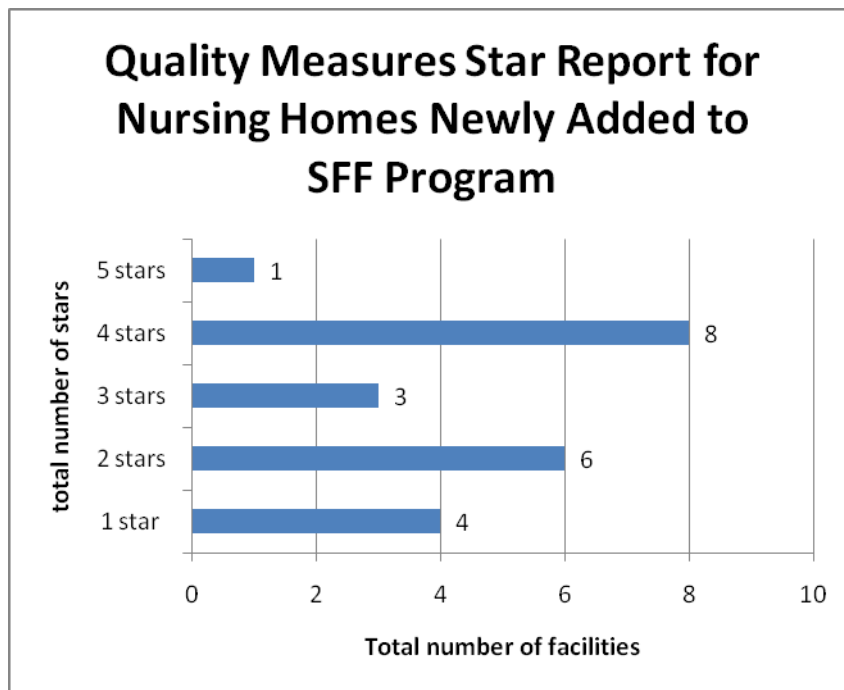
The 22 facilities added to the SFF list in May 2011, as expected, had poor survey results. All 22 received one star in their health surveys.



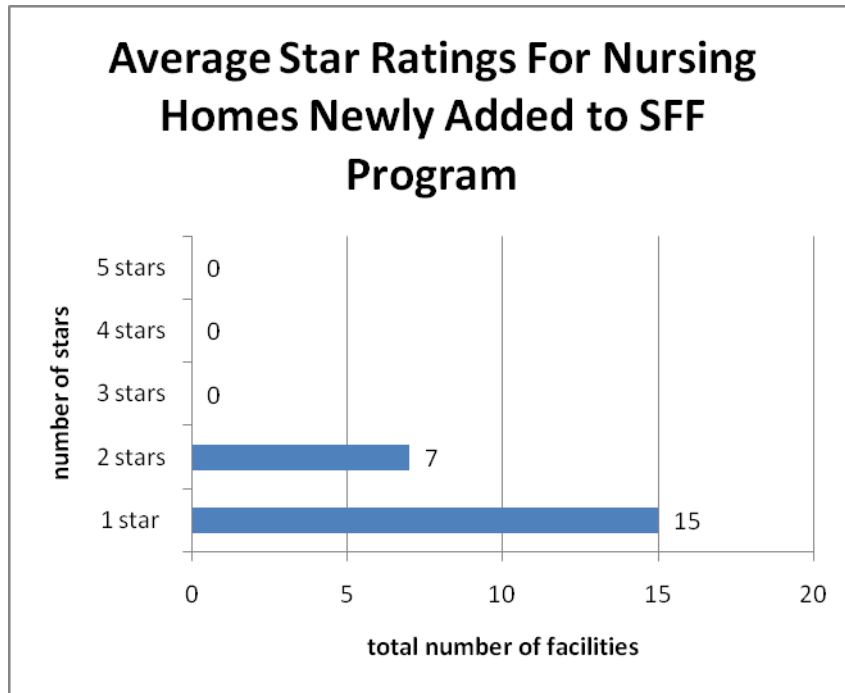
In contrast to health inspections, more than half (12 of 21 facilities with data (57%)) reported staffing levels that led to a star rating of four or five. Only one facility reported staffing levels that led to one star. One facility's staffing was not reported.



Newly-added SFFs also reported considerably higher quality measures, leading to higher star ratings for the facilities' quality measures. More than half the SFFs (12 of 22, 55%) reported quality measures that led to a star rating of three or higher. Only four of the 22 SFFs (18%) reported quality measures that led to a star rating of one.

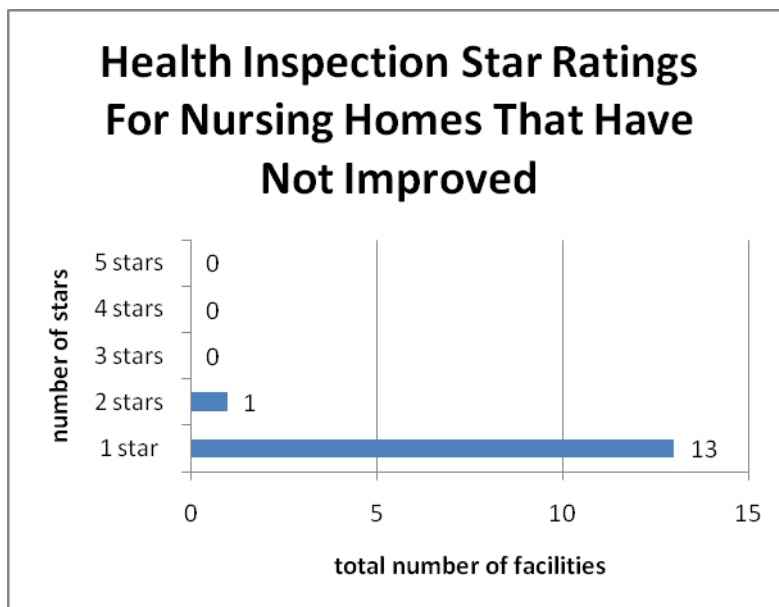


The composite ratings of the newly-added SFFs were mixed, reflecting the relatively higher staffing and quality measures that facilities reported. Approximately two-thirds (15 of the 22 facilities, 68%) newly-added to the SFF program were given a star rating of one out of five stars, but the remaining seven of 22 facilities (32%) were given a star rating of two.



Facilities that have not improved (14 facilities, Table B):

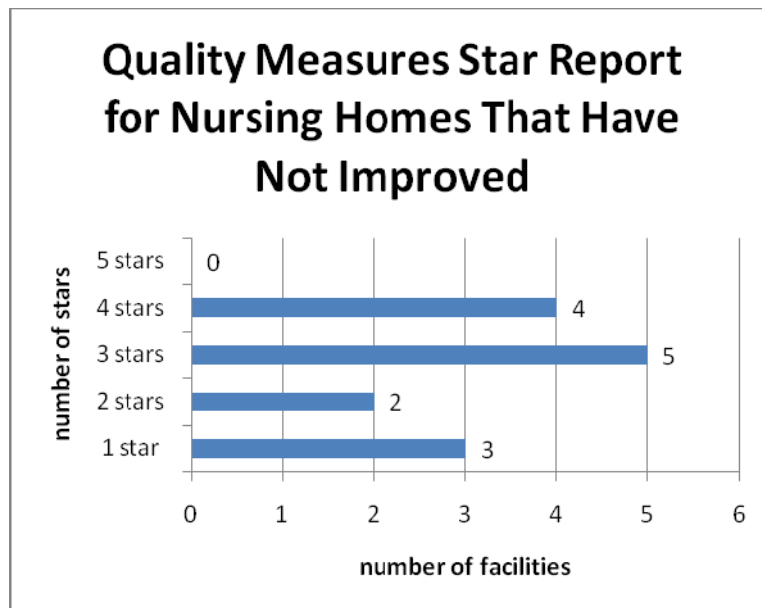
The health inspections of 13 of 14 facilities that had not improved remained at one star; the fourteenth facility had a two-star rating in health inspections.



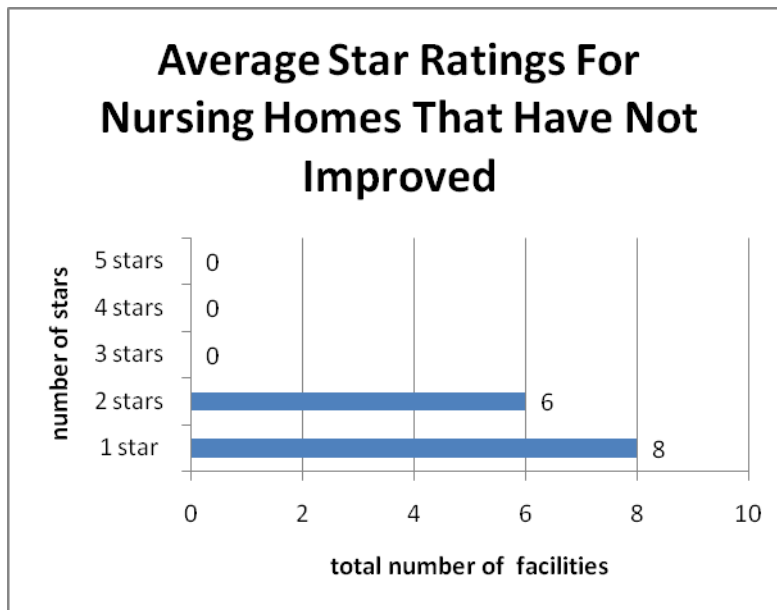
Non-improving SFFs reported high levels of staffing. More than half of the facilities (eight of 14 facilities, 57%) reported staffing levels that led to a four-star rating; six of 14 facilities (43%) reported staffing levels that led to one, two, or three stars in staffing.



The quality measures for non-improving SFFs were also considerably higher than the health survey star ratings. Nearly two-thirds of the facilities (nine of the 14 facilities, 64%) reported quality measures that led to star ratings of three and four. Just over one-third (five of 14 facilities, 36%) reported quality measures that led to star ratings of one or two.

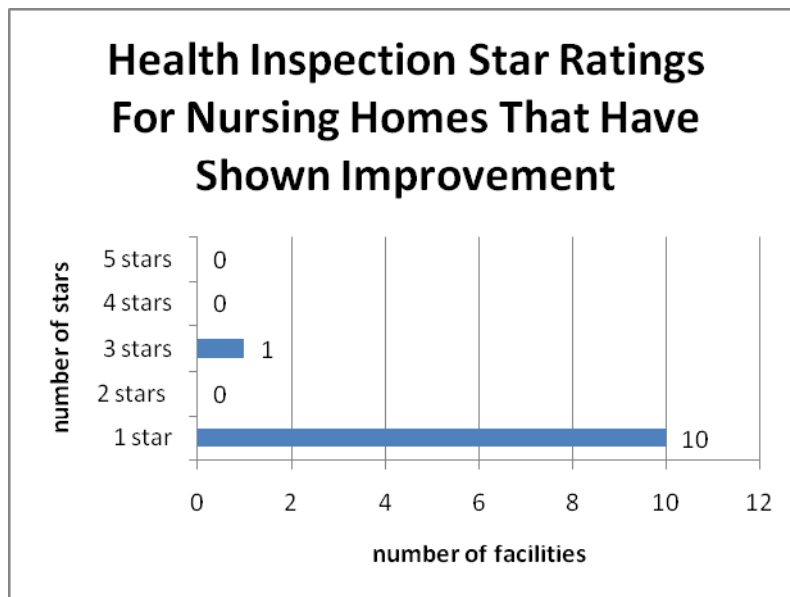


The composite ratings of facilities that have not improved were also mixed, reflecting the higher self-reported staffing and quality measure domains. Six of 14 facilities (43%) had two stars; eight of 14 facilities (57%), one star.

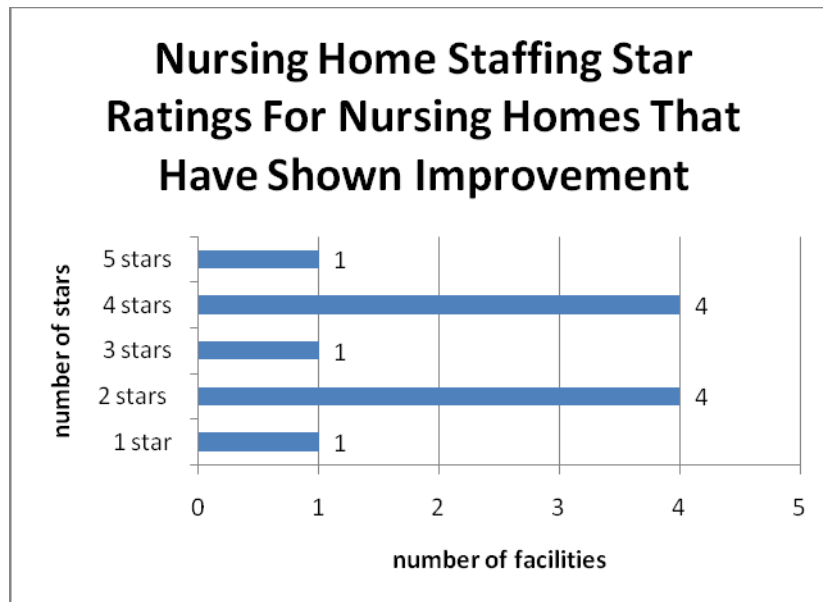


Facilities that have improved (11 facilities, Table C):

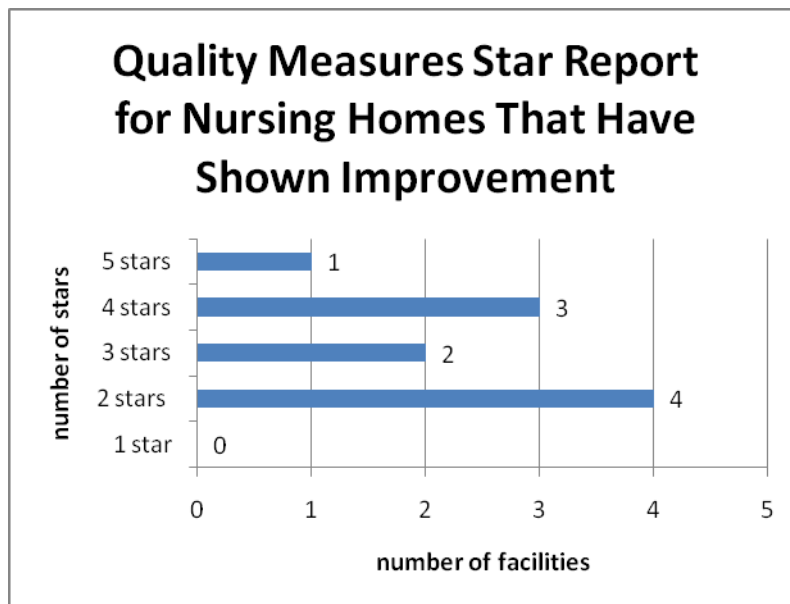
Ten of 11 facilities (91%) that showed improvement were still given one star on their health surveys; only one facility (9%) had a higher rating – three stars.



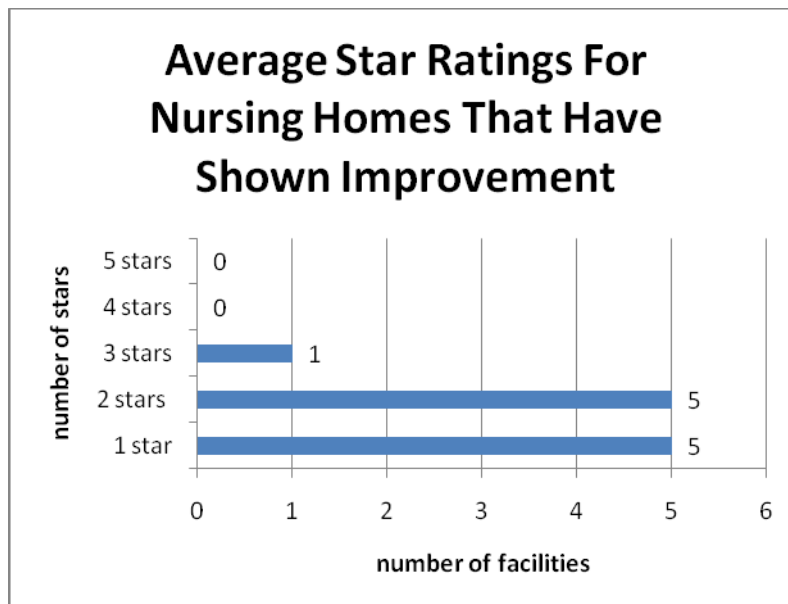
Facilities that had shown improvement also reported better staffing levels. Nearly half of the facilities (five of 11 facilities, 45%) reported staffing information that led to four- or five-star quality ratings; one of 11 facilities (9%) reported staffing information that led to a three-star quality rating; and five of 11 facilities (45%) reported staffing information that led to a one- or two-star quality rating.



No facilities that had shown improvement reported quality measures that gave them one star. Four of the 11 facilities that had shown improvement (36%) reported quality measures that led to a four or five star rating; two of 11 facilities (18%) reported quality measures that led to a three-star rating; and just over a third of the facilities (four facilities, 36%) reported quality measures that led to a one-star rating.



The composite ratings for facilities that have shown improvement reflected the higher quality measure and staffing star ratings. One of 11 facilities (9%) had three stars; five of the 11 facilities (45%) had two stars; and five of 11 facilities (45%) had one star.



Appendix 2

History of SFF program

The SFF program was one component of President Clinton’s July 1998 Nursing Home Initiative, although President Clinton did not use the term SFF to describe the two facilities in each state that would receive an additional survey each year.

After analyzing the data and finding some improvements in these poorly performing facilities that had an additional health survey each year, CMS created the Special Focus Facility Initiative in 2004 to strengthen the program. Under the program’s design, CMS devotes more surveyor attention to poorly performing facilities and takes progressively stronger enforcement action against them if they fail to improve within 18-24 months.²⁸

The first significant changes occurred in December 2004, when CMS

- Increased the number of facilities by about 30%, with more facilities in larger states;
- Improved the selection process for SFFs;
- Implemented stronger enforcement responses for facilities that did not improve; and
- Reduced the reporting burden for states.²⁹

In early November 2007, CMS began notifying governing bodies, owners, and operators of a facility’s designation as an SFF. It also began to make public the list of facilities that have been designated as SFFs and have failed to improve care significantly after one survey. Finally, CMS removed Life Safety Code deficiencies from the formula used to identify SFFs, allowing states to focus more on residents’ quality of care and quality of life.³⁰

In February 2008, CMS began publishing the names of all SFFs. In April 2008, CMS began using an icon on *Nursing Home Compare* to identify SFFs.

In August 2008, CMS directed each Quality Improvement Organization (QIO) to work with at least one SFF in its state under a “Nursing Homes in Need (NHIM)” initiative.³¹

CMS described the SFF scoring methodology in detail in October 2008. The scoring methodology uses the deficiency score and the revisit score. Health deficiencies cited during both the three most recent standard survey cycles and the last three years of complaint surveys are compiled and evaluated by CMS according to their scope (number of residents affected) and severity (whether residents suffered injury, harm, impairment, or death). The most recent survey data are scored most heavily. Additional points are added if the facility required more than one revisit to achieve substantial compliance with federal requirements. CMS compiles a list of 15 facilities in each state. States review the lists and, using additional state-specific knowledge (such as state survey results), recommend facilities to CMS.³²

CMS again clarified SFF procedures on September 17, 2010. It increased the total number of SFF slots nationally by 10% and gave states five candidates for each SFF slot. CMS also described the “progressive enforcement” applied to SFFs.

Progressive Enforcement Table

Surveys After SFF Selection	No Deficiencies cited at a Scope & Severity of “F” or Greater	Deficiencies at “F” or above (no improvement)	Immediate Jeopardy
1st Standard Survey	Complete 2nd Standard Survey	Immediately recommend remedy (CMP or DPNA at a minimum)	Recommend remedy and proceed to termination if not corrected.
2nd Standard Survey	Graduate (if 2 surveys with no deficiencies above “E”)	Recommend more stringent remedy. Must be in substantial compliance at 6 months or face termination.	Recommend remedy and proceed to termination if not corrected.
3rd Standard Survey	If a facility has deficiencies at E or below on the 3rd Standard Survey after selection (but is not able to graduate due to findings at F or above on 2nd Standard Survey or LSC deficiencies greater than F), Schedule 4th Standard Survey.	If a facility has deficiencies at G or above at the 3rd Standard Survey, Triage- (1) Schedule a 4th standard survey or (2) Issue a termination notice	Recommend remedy and proceed to termination if not corrected.
4th Standard Survey	Graduate (if 2 consecutive surveys with no deficiencies above “E”)	Triage - either (1) schedule 5th standard survey, or (2) issue a termination notice	Recommend remedy and proceed to termination if not corrected.
5th Standard Survey	Graduate (if 2 consecutive surveys with no deficiencies above “E”)	Issue termination notice (timing may be extended but not beyond statutory timeframes).	Recommend remedy and proceed to termination if not corrected.

States and CMS Regional Offices review SFFs that fail to make significant improvement after four standard surveys (24 months). The state recommends either a fifth standard survey (if the SFF is close to making significant improvement) or termination.³³

¹ American Health Care Association, “Improve Existing Nursing Home Survey System” (Issue Brief, July 1, 2011), http://www.ahcancal.org/advocacy/issue_briefs/Issue%20Briefs/IBImproveExistingNursingHomeSurveySystem.pdf.

² 42 U.S.C. §§1395i-3(g), 1396r(g), Medicare and Medicaid, respectively.

³ *Nursing Homes: Addressing the Factors Underlying Understatement of Serious Care Problems Requires Sustained CMS and State Commitment*. GAO-10-70 (Nov. 2009),

<http://www.gao.gov/new.items/d1070.pdf>.

Nursing Homes: Opportunities Exist to Facilitate the Use of the Temporary Management Sanction. GAO-10-37R (Nov. 2009), <http://www.gao.gov/new.items/d1037r.pdf>.

Nursing Homes: CMS's Special Focus Facility Methodology Should Better Target the Most Poorly Performing Homes, Which Tended to Be Chain Affiliated and For-Profit. GAO-09-689 (Aug. 2009), <http://www.gao.gov/new.items/d09689.pdf>.

Medicare and Medicaid Participating Facilities: CMS Needs to Reexamine Its Approach for Funding State Oversight of Health Care Facilities. GAO-09-64. (Feb. 2009), <http://www.gao.gov/new.items/d0964.pdf>.

Nursing Homes: Federal Monitoring Surveys Demonstrate Continued Understatement of Serious Care Problems and CMS Oversight Weaknesses. GAO-08-517 (May 2008),

<http://www.gao.gov/new.items/d08517.pdf>.

Nursing Home Reform: Continued Attention Is Needed to Improve Quality of Care in Small but Significant Share of Homes. GAO-07-794T (May 2007), <http://www.gao.gov/new.items/d07794t.pdf>.

Nursing Homes: Efforts to Strengthen Federal Enforcement Have Not Deterred Some Homes from Repeatedly Harming Residents. GAO-07-241 (March 2007), <http://www.gao.gov/new.items/d07241.pdf>.

Nursing Homes: Despite Increased Oversight, Challenges Remain in Ensuring High-Quality Care and Resident Safety. GAO-06-117 (Dec. 2005), <http://www.gao.gov/new.items/d06117.pdf>.

Nursing Home Quality: Prevalence of Serious Problems, While Declining, Reinforces Importance of Enhanced Oversight. GAO-03-561 (July 2003), <http://www.gao.gov/new.items/d03561.pdf>.

Nursing Homes: Sustained Efforts Are Essential to Realize Potential of the Quality Initiatives. GAO/HEHS-00-197 (Sep. 2000), <http://www.gao.gov/archive/2000/he00197.pdf>.

Nursing Home Care: Enhanced HCFA Oversight of State Programs Would Better Ensure Quality. GAO/HEHS-00-6 (Nov. 1999), <http://www.gao.gov/archive/2000/he00006.pdf>.

Nursing Homes: Proposal to Enhance Oversight of Poorly Performing Homes Has Merit. GAO/HEHS-99-157 (June 1999), <http://www.gao.gov/archive/1999/he99157.pdf>.

Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards. GAO/HEHS-99-46 (March 1999), <http://www.gao.gov/archive/1999/he99157.pdf>.

California Nursing Homes: Care Problems Persist Despite Federal and State Oversight. GAO/HEHS-98-202 (July 1998), <http://www.gao.gov/archive/1998/he98202.pdf>.

⁴ Bitá A. Kash, Catherine Hawes, Charles D. Phillips, "Comparing Staffing Levels in the Online Survey Certification and Reporting (OSCAR) System with the Medicaid Cost Report Data: Are Differences Systematic?" *The Gerontologist*, Vol. 47, No. 4, 480-489 (2007).

⁵ HCFA, *Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes*, Chapter 7 (Summer 2000).

⁶ HCFA, *Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes*, Phase II Final Report, Chapter 9, pages 9-1 – 9-2 (Winter 2001).

⁷ CMS, "Nursing Homes – Changes to Staffing Data on the Nursing Home Compare Web Site," S&C-05-24 (April 14, 2005), <https://www.cms.gov/SurveyCertificationGenInfo/downloads/SCLetter05-24.pdf>.

⁸ Affordable Care Act, §6106 (Ensuring Staffing Accountability), Social Security Act §1128I(g).

⁹ CMS, CMS, "Prudent Action for the FY 2012 Medicare Survey & Certification (S&C) Budget," S&C: 12-12-ALL (Dec. 9, 2011), https://www.cms.gov/Surveycertificationgeninfo/downloads/SCLetter12_12.pdf.

¹⁰ 42 U.S.C. §§1395i-3(b)(3)(C), 1396r(b)(3)(C), Medicare and Medicaid, respectively; 42 C.F.R. §483.20.

¹¹ 42 U.S.C. §§1395i-3(b)(3)(D), 1396r(b)(3)(D), Medicare and Medicaid, respectively.

¹² GAO, *Nursing Homes: Public Reporting of Quality Indicators Has Merit, but National Implementation Is Premature*, page 4, GAO-03-187 (Oct. 2002), <http://www.gao.gov/new.items/d03187.pdf>.

¹³ Anna Rahman, "Debate Looms on CMS Use of Pain Measure in Nursing Homes," *Aging Today*, Vol. XXVI, No. 2 (March-April 2005), http://www.asaging.org/at/at-262/Forum_Debate_Looms_On_CMS.cfm.

¹⁴ GAO, *Nursing Homes: Despite Increased Oversight, Challenges Remain in Ensuring High-Quality Care and Resident Safety*, GAO-06-117, page 34, note 50 (Dec. 2005), <http://www.gao.gov/new.items/d06117.pdf>.

¹⁵ Abt Associates, Inc., *Quality Monitoring for Medicare Global Payment Demonstrations: Nursing Home Quality-Based Purchasing Demonstration*, Final Design Report, page 43 (June 2006), http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/NHP4P_FinalReport.pdf.

¹⁶ *Id.*
¹⁷ Powerpoint presentation at CMS Open Door Forum on MDS 3.0, Slide 49 (Jan. 28, 2008), <http://www.cms.hhs.gov/OpenDoorForums/Downloads/MDS30Word012408.pdf>.

¹⁸ Rachel M. Werner, R. Tamara Konetzka, Elizabeth A. Stuart, and Daniel Polsky, "Changes in Patient Sorting to Nursing Homes to Nursing Homes under Public Reporting: Improved Patient Matching or Provider Gaming?" *Health Services Research*, Vol. 46, No. 2 (April 2011).

¹⁹ CMS, "CMS Issues Historic Star Quality Rating System for Nursing Homes; Next Step in Evolution of Nursing Home Compare Web Site" (Press Release, Dec. 18, 2008), <http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=3383&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date>

²⁰ CMS, *Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Phase II Final Report* (2002).

²¹ CMS, *Quality Measures*, https://www.cms.gov/NursingHomeQualityInits/10_NHQIQualityMeasures.asp.

²² *Id.*
²³ <http://www.gpo.gov/fdsys/pkg/BILLS-111hr6074ih/pdf/BILLS-111hr6074ih.pdf>. The bill would also permit contractors to conduct surveys, limit when the Secretary could conduct a survey, require surveys to identify both "positive aspects of care and facility life" as well as "aspects of care that may need improvement," and use civil money penalties to develop acuity adjusters.

²⁴ American Health Care Association, "Improve Existing Nursing Home Survey System" (Issue Brief, July 1, 2011), http://www.ahcancal.org/advocacy/issue_briefs/Issue%20Briefs/IBImproveExistingNursingHomeSurveySystem.pdf.

²⁵ Task Force on Survey, Certification and Enforcement, AAHSA, *Broken and Beyond Repair: Recommendations to Reform The Survey and Certification System*, page 15 (June 2008). Although the report is not available on Leading Age's website, an August statement by Leading Age refers to the report. Leading Age, "Why the Latest GAO Report Reinforces Need for Survey Reform" (Statement by Dr. Cheryl Phillips, Aug. 19, 2011), http://www.leadingage.org/Why_the_Latest_GAO_Report_Reinforces_Need_for_Survey_Reform.aspx.

²⁶ *Id.* 17.

²⁷ *Id.* 48.

²⁸ CMS, "Special Focus Facility Initiative," <http://www.cms.gov/CertificationandCompliance/Downloads/SFFList.pdf>.

²⁹ CMS, "Improving Enforcement via the Special Focus Facility Program," S&C 05-13 (Dec. 16, 2004), <https://www.cms.gov/SurveyCertificationGenInfo/downloads/SCLetter05-13.pdf>.

³⁰ CMS, "National Special Focus Facility Program Improvements for Nursing Facilities, Notice Requirements," S&C-08-02 (Nov. 5, 2007, revised Dec. 7, 2007), <https://www.cms.gov/SurveyCertificationGenInfo/downloads/SCLetter08-02.pdf>.

³¹ CMS, "State Survey Agency (SA) Selection of Special Focus Facilities (SFF) for Technical Assistance by Quality Improvement Organizations (QIOs) – New 9th Scope of Work Item – Nursing Homes in Need (NHIN) Task," S&C-08-32 (Aug. 15, 2008), <https://www.cms.gov/SurveyCertificationGenInfo/downloads/SCLetter08-32.pdf>.

³² CMS, "Special Focus Facility (SFF) Program Survey Scoring Methodology," S&C-09-05 (Oct. 10, 2008), <https://www.cms.gov/SurveyCertificationGenInfo/downloads/SCLetter09-05.pdf>.

³³ CMS, "Special Focus Facilities (SFF) Procedures," S&C-10-32-NH (Sep. 17, 2010), https://www.cms.gov/Surveycertificationgeninfo/downloads/SCLetter10_32.pdf.