# Department of Health and Human Services

## OFFICE OF INSPECTOR GENERAL

# HOME HEALTH AGENCIES RECEIVED TIMELY SURVEYS AND CORRECTED DEFICIENCIES AS REQUIRED

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## EXECUTIVE SUMMARY: HOME HEALTH AGENCIES RECEIVED TIMELY SURVEYS AND CORRECTED DEFICIENCIES AS REQUIRED
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### WHY WE DID THIS STUDY

Over the last decade, the use of home health services increased significantly and Medicare payments to home health agencies (HHA) more than doubled. To ensure that HHAs comply with Federal requirements, the Centers for Medicare & Medicaid Services (CMS) contracts with each State survey agency (State agency) and three accreditation organizations to conduct initial certification surveys of HHAs, recertification surveys, and complaint investigations. CMS also monitors the performance of accreditation organizations by contracting with State agencies to perform "look-behind" surveys of HHAs recently surveyed by accreditation organizations. CMS compares an accreditation organization's survey of an individual HHA with a State agency's subsequent survey of the same HHA, and then uses that information in aggregate to evaluate the accreditation organization's overall survey performance. A 2008 study by the Office of Inspector General (OIG) found that many HHAs had the same deficiencies cited during multiple recertification surveys and CMS rarely used the only sanction available—termination—to address HHA noncompliance.

### HOW WE DID THIS STUDY

Using CMS data for Federal fiscal years 2010 and 2011, we identified the extent to which State agencies and accreditation organizations conducted timely recertification surveys of HHAs. We also identified the extent to which HHAs received deficiency citations, corrected deficiencies, or had complaints lodged against them. Additionally, we determined the extent to which CMS used look-behind surveys to assess the performance of accreditation organizations and State agencies.

### WHAT WE FOUND

State agencies and accreditation organizations conducted recertification surveys for nearly all HHAs within the required 36-month timeframe and cited 12 percent of HHAs with "condition"-level deficiencies, the most serious type of deficiency. Ninety-three percent of these HHAs corrected their condition-level deficiencies within the required 90-day timeframe; the remaining 7 percent corrected the deficiencies late or left Medicare. Fifteen percent of HHAs had complaints lodged against them; surveyors conducted complaint investigation surveys for nearly all of these HHAs and cited 7 percent of them with condition-level deficiencies. With few exceptions, HHAs corrected all condition-level deficiencies cited during complaint surveys. State agencies exceeded the required number of look-behind surveys for oversight of accreditation organizations. CMS rarely conducted look-behind surveys for oversight of State agencies' surveys of HHAs; such look-behind surveys are not required by Federal regulation.

### WHAT WE RECOMMEND

We recommend that CMS analyze survey data to determine whether it should routinely conduct look-behind surveys for oversight of State agencies, which conduct most HHA recertification surveys. CMS concurred with our recommendation and stated that its central office will work with the CMS regional offices to identify State agencies with the greatest need for look-behind surveys.

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## OBJECTIVES

1. To determine the extent to which State survey agencies (State agencies) and accreditation organizations conducted recertification surveys of home health agencies (HHA) within required timeframes during fiscal years (FY) 2010–11.[1]
2. To determine the extent to which HHAs received deficiency citations on recertification surveys and the nature and resulting actions of those deficiencies during FYs 2010–11.
3. To determine the extent to which HHAs had complaints lodged (i.e., allegations made) against them, the nature of those complaints, and the actions resulting from those complaints during FYs 2010–11.
4. To determine the extent to which the Centers for Medicare & Medicaid Services (CMS) used "look-behind" surveys to assess the performance of surveyors during FYs 2010–11.

## BACKGROUND

HHAs provide home health services for Medicare beneficiaries with short- or long-term illnesses or injuries who are confined to their homes and need skilled nursing care on an intermittent basis, physical therapy, speech therapy and/or continuing occupational therapy.[2] In recent years, the use of Medicare home health services has grown. From 2002 to 2010, Medicare beneficiaries receiving home health services increased by nearly 35 percent (from 2.6 to 3.4 million beneficiaries), and the number of Medicare-certified HHAs increased by 69 percent (from 6,813 to 11,548 HHAs).[3, 4] In 2010, Medicare paid $19.5 billion for home health services, compared to $9.6 billion in 2002.

### Survey and Certification of Home Health Agencies

All HHAs participating in the Medicare program must comply with 15 Medicare Conditions of Participation (CoP).[5] The CoPs fall into two areas: administration and furnishing of services. Twelve of the

[1] All fiscal year references in this report are based on the Federal fiscal year (October 1 through September 30).

[2] Social Security Act, §§ 1812(a)(3), 1814(a)(2)(C), 1832(a)(2)(A), 1835(a)(2)(A), and 1861(m).

[3] CMS, *Data Compendium*, 2003, 2011. Accessed at https://www.cms.gov on May 23, 2012. From 2002 to 2010, the number of Medicare beneficiary visits conducted by HHAs increased by 60 percent (from 78.1 million visits to 124.7 million visits).

[4] CMS, *Financial Report*, 2011, p. 138.

[5] Social Security Act §§ 1861(o)(6) and 1891(a); 42 CFR pt. 484 (subparts B and C).

fifteen CoPs are subdivided into "standards," which address specific aspects of the CoPs.[6]

To ensure compliance with the 15 CoPs, CMS enters into agreements with State agencies and accreditation organizations to conduct initial certification surveys of HHAs, recertification surveys, and complaint investigations.[7] In this report, we use the term "surveyors" to refer to both State agencies and accreditation organizations.

*Recertification Surveys*. Federal law requires that HHAs receive a recertification survey at least every 36 months to verify compliance with the CoPs.[8] Recertification surveys review "the quality of care and services furnished by the agency as measured by indicators of medical, nursing, and rehabilitative care," and include patient home visits and interviews with patients and HHA staff.[9] Recertification surveys also include a review of previous survey data (if available), complaint data, and clinical records.[10]

*Deficiency Citations*. If a surveyor determines that an HHA is out of compliance with a standard during a recertification survey, the surveyor can cite the HHA with a "standard-level deficiency." If the surveyor determines that the HHA is out of compliance with a CoP, the surveyor can cite the HHA with a "condition-level deficiency," the more serious type of deficiency.[11]

*Correcting Deficiencies*. If an HHA has one or more condition-level deficiencies, it is considered out of compliance with the CoPs. For such noncompliance, the surveyor must provide the HHA with a Statement of

[6] The three CoPs that are not defined further by standards are: release of patient identifiable Outcome and Assessment Information Set (OASIS) information (42 CFR § 484.11); qualifying to furnish outpatient physical therapy or speech pathology services (42 CFR § 484.34); and medical social services (42 CFR § 484.38).

[7] Social Security Act, §§ 1891(c)(2)(A) and 1865(a); 42 CFR § 488.10(d). The three accreditation organizations approved to conduct surveys are the Accreditation Commission for Health Care, the Community Health Accreditation Program, and the Joint Commission.

[8] Social Security Act, § 1891(c)(2)(A); CMS, pt. I, section II.E, Recertification Surveys, of the Advance Copy of App. B to CMS, *State Operations Manual*, Pub. No. 100-07 (*SOM, Advance App. B*), attached to CMS Memorandum to State Survey Agency Directors, S&C 11-11-HHA, February 11, 2011 (effective May 1, 2011). For HHA recertification surveys, CMS includes 90 percent of the succeeding month to permit completion of any survey in progress. See CMS, Division of Survey and Certification, Quality Assurance for the Medicare & Medicaid Programs, *FY 2011 Mission & Priority Document*, September 3, 2010 (revised October 15, 2010).

[9] Social Security Act, § 1891(c)(2)(C)(i)(II); CMS, *SOM, Advance App. B*, pt. I, section II.B, Standard Survey.

[10] CMS, *SOM, Advance App. B*, pt. I, section II.E, Recertification Surveys, and pt. I, section III, Task 1, Pre-Survey Preparation.

[11] CMS, *SOM, Advance App. B*, pt. I, section III, Task 4, Information Analysis.

Deficiencies and Plan of Correction form that includes evidence to support the deficiency citation(s) and a section that HHAs can use to document a plan of correction. The HHA must respond with a plan of correction within 10 calendar days of receiving this form.[12] If an HHA with standard-level deficiencies submits an acceptable plan of correction for achieving compliance within a reasonable period of time, which is generally no longer than 60 days after notification of the deficiencies, the surveyor will certify the HHA as in compliance with the CoPs.[13]

For an HHA with one or more condition-level deficiencies, a surveyor cannot certify compliance based solely on a plan of correction. In these cases, CMS must place the HHA on a 90-day termination track (the only enforcement remedy currently available to CMS).[14, 15] To continue participating in Medicare, the HHA must submit a "credible allegation of compliance," and achieve compliance or acceptable progress within the 90-day timeframe.[16] If a surveyor documents "immediate jeopardy" to patient health and safety, the State agency must place the HHA on a 23-day termination track, using the same procedures as the 90-day termination track.[17]

*Complaint Investigations*. Medicare beneficiaries, families of beneficiaries, HHA staff, physicians, and others can lodge complaints against HHAs to a variety of entities, including State agencies, accreditation organizations, and CMS. CMS and State agencies track complaints lodged, categorize them into different severity levels, and determine actions to take (e.g., referral to another agency, offsite

[12] CMS, *SOM*, Pub. No. 100-07, ch. 2, §§ 2728, 2728A, and 2728B.

[13] Ibid. An acceptable plan of correction must include the following elements: plan of correcting the specific deficiency and addressing the processes that led to the deficiency cited; procedure for implementing the acceptable plan of correction for the specific deficiency cited; monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; and title of the person responsible for implementing the acceptable plan of correction.

[14] CMS, *SOM*, ch. 3, § 3012.

[15] On November 8, 2012, CMS issued a final rule to implement intermediate (or alternative) sanctions for noncompliant HHAs. For more information on this rule, see the "Other Studies" section on page 6.

[16] CMS, *SOM*, ch. 3, § 3016A. "Credible allegation of compliance" is defined as "a statement or documentation: that is realistic in terms of the possibility of corrective action being accomplished between the exit conference and the date of allegation; and that indicates resolution of the problems."

[17] CMS, *SOM*, ch. 3, § 3010B.

investigation, onsite investigation) on the basis of those severity levels.[18] CMS and State agencies categorize lodged complaints into one of eight severity levels, and CMS requires surveyors to conduct complaint investigation surveys (hereafter referred to as complaint surveys) for the three most severe of these:

- Immediate jeopardy: Provider's noncompliance with the CoPs has caused or is likely to cause serious injury, harm, impairment, or death.[19]
- Non-immediate jeopardy high: Provider's noncompliance with the CoPs may have caused harm that negatively affects the individual's mental, physical, and/or psychosocial status and is of such consequence to the person's well-being that a rapid response by the State agency is indicated.[20]
- Non-immediate jeopardy medium: Provider's noncompliance with the CoPs caused or may cause harm that is of limited consequence and does not significantly impair the individual's mental, physical, and/or psychosocial status or function.[21]

Surveyors conducting complaint surveys focus on the specific regulatory requirements related to the complaint lodged. If surveyors identify significant problems, the surveyors can expand the survey to review the HHA's compliance with other CoPs.[22] If surveyors find evidence supporting the complaint, the surveyors substantiate the complaint.[23] During a complaint survey, surveyors not only determine whether the complaint is substantiated, but also cite any deficiencies found, which may or may not directly relate to the complaint. If surveyors find condition-level deficiencies, they can place the HHA on a termination track. To continue participating in Medicare, the HHA must submit an

[18] CMS, *SOM*, ch. 5, §§ 5075.1–5075.8. CMS and State agencies categorize lodged complaints into one of the following eight severity levels: immediate jeopardy, non-immediate jeopardy high, non-immediate jeopardy medium, non-immediate jeopardy low, administrative review/offsite investigation, immediate referral, other referral, and no action necessary.

[19] CMS, *SOM*, ch. 5, § 5075.1, p. 14.

[20] CMS, *SOM*, ch. 5, § 5075.2, p. 15. Although the *SOM* states that only nursing home complaints—as opposed to complaints regarding other facilities—can be categorized at the level "non-immediate jeopardy high," a CMS official explained that some complaints lodged against HHAs are also categorized at this level and require complaint surveys within 2 or 10 days.

[21] CMS, *SOM*, ch. 5, § 5075.3, p. 16.

[22] CMS, *SOM*, ch. 5, § 5200.1, p. 33.

[23] CMS, *SOM*, ch. 9, Exhibit 23.

acceptable plan of correction, as it does when deficiencies are cited during a recertification survey.[24]

For the other five levels of complaints lodged, the surveyor can wait until the next survey to review the issue related to the complaint.[25] Additionally, surveyors can refer the complaint to another agency or entity (e.g., law enforcement or licensure agency) for investigation or for informational purposes.[26]

### "Look-Behind" Surveys of Accreditation Organizations and State Agencies

Federal law requires that CMS annually report to Congress about the performance of accreditation organizations.[27] To assess these organizations' performance, CMS enters into agreements with State agencies for the agencies to annually conduct "look-behind" surveys of a representative sample of at least 5 percent of HHAs surveyed by accreditation organizations.[28] These surveys (which CMS refers to as "validation surveys") enable CMS to compare an accreditation organization's results for an individual HHA with those from a State agency's subsequent survey of the same HHA.

The look-behind survey, which a State agency must conduct no later than 60 days following an accreditation organization's survey of the same HHA, reviews the HHA's compliance with the CoPs. During a look-behind survey, the State agency can cite the HHA with deficiencies in the same way as during a certification or recertification survey. Once the State agency completes the survey, it provides CMS with the survey results. For each HHA that receives a look-behind survey, CMS compares the condition-level deficiencies identified by the State agency to those identified by the accreditation organization.[29] CMS uses this information in aggregate to calculate a disparity rate, which is the percentage of all look-behind surveys in which the accreditation organization missed a condition-level deficiency identified by a State agency.[30]

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[24] CMS, *SOM*, ch. 5, § 5200.1, p. 33.

[25] CMS, *SOM*, ch. 5, §§ 5075.4, 5075.5, and 5075.8.

[26] CMS, *SOM*, ch. 5, §§ 5075.6–5075.7.

[27] Social Security Act, § 1875(b).

[28] CMS, Division of Survey and Certification, *Quality Assurance for the Medicare & Medicaid Programs, FY 2011 Mission & Priority Document*, September 3, 2010 (revised October 15, 2010).

[29] CMS, *Financial Report*, 2010, p. 152.

[30] Ibid., p. 154. The disparity rate is calculated by taking the number of look-behind surveys in which a State agency found at least one condition-level deficiency that a given accreditation organization had missed for the same HHA, and dividing it by the total number of look-behind surveys for that accreditation organization.

Federal law does not require CMS to conduct look-behind surveys to assess State agencies' performance in surveying HHAs, but CMS may conduct such surveys if it wishes. In these cases, CMS itself conducts the look-behind survey of an HHA, rather than contracting with another entity to do it. CMS then compares its results for an individual HHA with the State agency's results for the same HHA. Although look-behind surveys to evaluate State agencies' performance (surveys that CMS refers to as "Federal monitoring surveys") are not required vis-à-vis State agencies' surveys of HHAs, they *are* required for State agencies' surveys of nursing homes, which serve beneficiary populations similar to those of HHAs, and CMS routinely conducts such surveys.[31]

### Other Studies

A 2008 report by the Office of Inspector General (OIG) found that many HHAs had the same deficiencies cited during multiple recertification surveys.[32] Further, the study found that CMS rarely used the only sanction available—termination—to address HHAs with repeated deficiencies. In the report, OIG recommended that CMS implement intermediate sanctions for HHAs as required by the Omnibus Budget Reconciliation Act of 1987.[33] In March 2012, OIG reiterated this recommendation in an early alert memorandum to CMS that outlined CMS's limited action toward promulgating regulations for the HHA intermediate sanctions.[34] In November 2012, CMS issued a final rule to implement intermediate (or alternative) sanctions for noncompliant HHAs. The first set of sanctions, which will become effective on July 1, 2013, includes temporary management, directed plans of correction, and directed in-service training. Two additional sanctions—civil money penalties and suspension of Medicare payments for new patient admissions—will become effective on July 1, 2014.[35]

[31] Social Security Act, §§ 1819(g)(3)(B)(Medicare) and 1919(g)(3)(B)(Medicaid); CMS, *SOM*, ch. 4, § 4157D. Federal law requires CMS to conduct look-behind surveys of at least 5 percent of the number of nursing homes surveyed by each State agency each year, but in no case is CMS to survey fewer than five nursing homes in each State per year.

[32] Department of Health and Human Services (DHHS), OIG, *Deficiency History and Recertification of Medicare Home Health Agencies*, OEI-09-06-00040, August 2008.

[33] Omnibus Budget Reconciliation Act of 1987, P.L. 100-203, § 4023 (adding Social Security Act, §§ 1891(e) and (f)).

[34] DHHS, OIG, *Early Alert Memorandum Report: Intermediate Sanctions for Noncompliant Home Health Agencies*, OEI-06-11-00401, March 2012.

[35] 77 Fed. Reg. 67068 (November 8, 2012).

# METHODOLOGY

## Scope

This evaluation examines all Medicare-certified HHAs that received a recertification survey, had a complaint lodged against them, and/or received a look-behind survey during FYs 2010–11. Consequently, this evaluation does not include HHAs that did not receive a recertification survey during FYs 2010–11.

## Data Collection and Analysis

To analyze all HHA recertification surveys and complaints during FYs 2010–11, we obtained data from three CMS databases: the Automated Survey Processing Environments (ASPEN), the Certification and Survey Provider Enhanced Reporting (CASPER), and the Accrediting Organization System for Storing User Recorded Experiences (ASSURE). ASPEN and CASPER store data from recertification surveys conducted by State agencies and include all HHA enrollment, termination, and complaint data. ASSURE stores data from HHA recertification surveys conducted by accreditation organizations. To analyze look-behind surveys, we obtained copies of Statement of Deficiencies forms from CMS.

*Recertification Surveys.* We identified all HHAs that received a recertification survey during FYs 2010–11, using data from ASPEN and CASPER for surveys conducted by State agencies and ASSURE for surveys conducted by accreditation organizations.[36] To identify and calculate the percentage of HHAs that received a recertification survey within the required timeframe, we counted the number of working days since the prior recertification survey date.[37] For each recertification survey, we identified all deficiency citations and calculated the percentage of HHAs with citations. We focused additional analysis on citations for condition-level deficiencies, the more serious of the two kinds of deficiencies. We identified whether HHAs corrected their condition-level deficiencies, returned to compliance within the required 90-day timeframe, or were terminated from Medicare. For each scenario, we calculated the associated percentage of HHAs.

[36] This analysis included only recertification surveys, not other types of surveys such as initial certification surveys.

[37] We used 36.9 months as our criteria for calculating surveys conducted within the required timeframe because CMS includes 90 percent of the succeeding month to permit completion of any survey in progress. See CMS, Division of Survey and Certification, *Quality Assurance for the Medicare & Medicaid Programs, FY 2011 Mission & Priority Document*, September 3, 2010 (revised November 15, 2010).

*Complaints and Complaint Surveys*. We used ASPEN to identify all HHAs that had a complaint lodged against them alleging noncompliance during FYs 2010–11.[38] We calculated the percentage of HHAs with any complaints lodged and identified the severity of those complaints. We also calculated the percentage of HHAs with substantiated complaints and the percentage of HHAs that received a complaint survey. Although ASPEN indicated that HHAs received a complaint survey, ASPEN did not contain records of the survey results for all HHAs. More specifically, it was missing one or more survey records for 261 HHAs that received a complaint survey.[39] As a result, our analysis of complaint surveys included only HHAs for which ASPEN had survey records.[40] For each complaint survey, we identified all deficiency citations and calculated the percentage of HHAs with such citations. We focused additional analysis on citations for condition-level deficiencies and identified whether HHAs corrected these deficiencies, returned to compliance within the required 90-day timeframe, or were terminated from Medicare.

*Look-Behind Surveys*. We identified all HHAs that received a look-behind survey during FYs 2010–11 using Statement of Deficiencies forms obtained from CMS. For State agencies, we identified whether surveyors each year collectively conducted look-behind surveys of 5 percent of HHAs surveyed by accreditation organizations, as required by CMS. For each look-behind survey, we identified condition-level deficiencies cited by State agencies but missed by accreditation organizations. Using this information, we calculated a disparity rate across the three accreditation organizations. Lastly, we identified the extent to which CMS voluntarily conducted look-behind surveys of State agency-surveyed HHAs to assess State agencies' performance.

## Limitations

This study has two limitations. First, we did not compare deficiency citation rates between HHAs surveyed by State agencies and those surveyed by accreditation organizations because the surveying entities conduct recertification surveys differently—though all State agencies use similar survey instruments and methodology, each accreditation organization uses its own process. Moreover, although accreditation organizations must match their deficiency citations to those used by State

[38] In our analysis, we did not include any complaints unrelated to the Federal requirements, such as complaints related solely to State matters, which were outside the scope of the study.

[39] A CMS official indicated that a failure of the complaint survey records to upload into ASPEN may likely be the cause of the missing records.

[40] This analysis includes only complaint surveys, not other types of surveys such as initial certification surveys.

agencies, a deficiency cited by an accreditation organization may not correspond directly to a deficiency cited by a State agency. Second, we could not include all HHAs that received a complaint survey in our analysis because ASPEN was missing one or more complaint survey records for 261 HHAs.

### Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

## FINDINGS

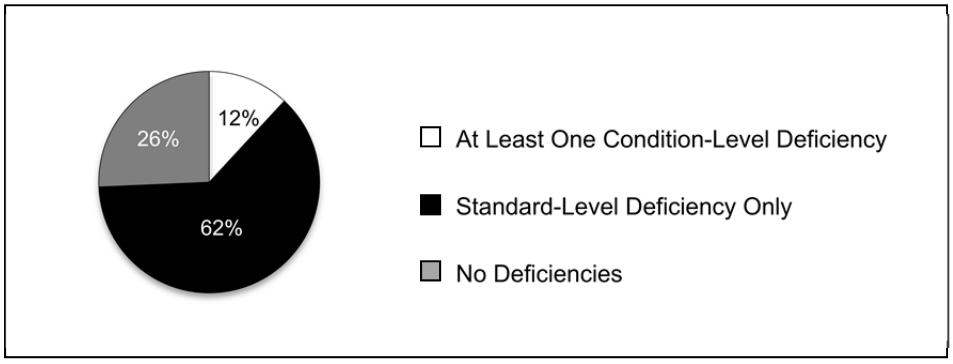
### Surveyors conducted recertification surveys on time for 98 percent of HHAs and cited 12 percent of HHAs with condition-level (i.e., serious) deficiencies

Surveyors conducted recertification surveys of 6,316 HHAs during FYs 2010–11. Eighty-two percent of these HHAs (5,210) were surveyed by State agencies, whereas 18 percent (1,106) were surveyed by accreditation organizations. Ninety-eight percent of these 6,316 HHAs (6,190) received a recertification survey within the required 36-month timeframe. For the remaining 2 percent of HHAs (126), surveyors were late in conducting the survey by a median of 3.3 months. Of the 126 HHAs that were surveyed late, 32 HHAs were not surveyed until more than a year after the required 36-month timeframe.

#### *Collectively, surveyors cited 12 percent of HHAs with at least one condition-level deficiency, but citation varied widely by State agency and by accreditation organization*

Among the 6,316 HHAs that received a recertification survey, surveyors cited deficiencies—including both standard-level and condition-level deficiencies—for 74 percent (4,694). For the remaining 26 percent of HHAs (1,622), surveyors cited no deficiencies. Among the 74 percent of HHAs with deficiencies, surveyors cited 62 percent (3,942 of 6,316) with standard-level deficiencies only, and cited an additional 12 percent (752 of 6,316) with at least one condition-level deficiency, the more serious type of deficiency (see Figure 1).

**Figure 1: HHAs With Deficiency Citations on Recertification Surveys**




Source: OIG analysis of 6,316 HHAs' recertification surveys in FYs 2010–11.

Among the HHAs with condition-level deficiencies, surveyors found noncompliance across all 15 CoPs and cited a total of 1,736 condition-level deficiencies. Fifty-four percent of these HHAs (409 of 752) received two or more condition-level deficiency citations.[41] The HHA with the most condition-level deficiencies was cited for 13 of the 15 CoPs.

The most frequently cited condition-level deficiency among these HHAs, cited for 35 percent of HHAs (265 of 752), involved noncompliance with "acceptance of patients, plan of care, and medical supervision." (Table 1 lists the number and percentage of HHAs with condition-level deficiencies in each of the 15 CoPs.)

**Table 1: HHAs Cited With Condition-Level Deficiencies, by Condition of Participation**

| Condition of Participation* | HHAs Cited With Condition-Level Deficiency (n=752) | Percentage |
|---|---|---|
| Acceptance of patients, plan of care and medical supervision | 265 | 35% |
| Organization, services and administration | 241 | 32% |
| Skilled nursing services | 200 | 27% |
| Clinical records | 183 | 24% |
| Evaluation of the agency's program | 157 | 21% |
| Comprehensive assessment of patients | 145 | 19% |
| Reporting OASIS information | 145 | 19% |
| Group of professional personnel | 130 | 17% |
| Home health aide services | 129 | 17% |
| Patient rights | 42 | 6% |
| Therapy services | 42 | 6% |
| Compliance with Federal, State, and local laws | 30 | 4% |
| Medical social services | 21 | 3% |
| Release of patient personally identifiable information | 5 | <1% |
| Outpatient physical therapy or speech pathology services | 1 | <1% |

Note: Some HHAs had more than one recertification survey and could have received a condition-level deficiency citation for the same CoP more than once; however, we counted each HHA only once for each CoP.
*See 42 CFR pt. 484 (subparts B and C).
Source: OIG analysis of 752 HHAs cited with condition-level deficiencies on recertification surveys in FYs 2010–11.

Surveyors varied in the percentages of HHAs they cited with condition-level deficiencies during recertification surveys. State agencies gave condition-level deficiency citations to between 0 and 50 percent of the HHAs they surveyed. Despite conducting recertification surveys for

[41] Surveyors cited 343 HHAs with 1 condition-level deficiency, 164 HHAs with 2, 107 HHAs with 3, and 138 HHAs with 4 or more condition-level deficiencies.

multiple HHAs, nine State agencies did not cite any condition-level deficiencies, whereas eight State agencies cited condition-level deficiencies for 20 percent or more of the HHAs receiving recertification surveys. (See Appendix A-1 for the number and percentage of HHAs that were cited for condition-level deficiencies, by State.) Accreditation organizations gave condition-level deficiency citations to between 8 and 33 percent of the HHAs they surveyed. (See Appendix A-2 for the number and percentage of HHAs with condition-level deficiencies, by accreditation organization.)

## Among the HHAs with condition-level deficiencies, 93 percent corrected all deficiencies within required timeframes

Surveyors placed nearly all HHAs with condition-level deficiencies (741 of 752) on a 90-day termination track. Ninety-three percent of HHAs (692 of 741) with condition-level deficiencies corrected all deficiencies and returned to compliance within the required 90-day timeframe. These HHAs returned to compliance an average of 38 days following the recertification survey.

The remaining 7 percent of HHAs (49 of 741) did not return to compliance within the 90-day timeframe. Among these 49 HHAs, 33 corrected their deficiencies shortly after the 90-day timeframe, returning to compliance an average of 130 days following the recertification survey. However, one HHA did not return to compliance until more than a year after the recertification survey. A CMS official explained that HHAs likely exceeded the timeframe because surveyors did not conduct timely followup visits or provide the HHAs with a statement of deficiencies, typically resulting in an extension of the termination date. Another 16 of the 49 HHAs never corrected their condition-level deficiencies; CMS terminated the Medicare participation for 8 of these HHAs, and 3 HHAs voluntarily discontinued their participation. The remaining five HHAs continued participation in Medicare, yet CMS could not determine whether the HHAs corrected their deficiencies.

## Surveyors conducted complaint surveys for virtually all of the 15 percent of HHAs that had complaints lodged against them

CMS received 5,888 complaints concerning 1,784 HHAs (15 percent of all HHAs) in FYs 2010–11. CMS classified the complaints[42] lodged against

[42] In this report, the term "complaint" means (unless specified otherwise) a complaint that has been lodged—i.e., an allegation.

7 percent of HHAs (126 of 1,784) as immediate jeopardy, the most severe level of complaint. The most common severity level of complaints lodged was non-immediate jeopardy medium, accounting for 78 percent of all HHAs (1,387) with complaints lodged against them. (Table 2 lists the number and percentage of HHAs with complaints lodged against them, categorized by severity level.)

**Table 2: Complaints Lodged Against HHAs, by Severity Level**

| Severity Level of Complaints Lodged (Most Severe to Least Severe) | HHAs With Complaints Lodged Against Them (n=842) | Percentage |
|---|---|---|
| Immediate jeopardy | 126 | 7% |
| Non-immediate jeopardy high | 143 | 8% |
| Non-immediate jeopardy medium | 1,387 | 78% |
| Non-immediate jeopardy low | 239 | 13% |
| Non-immediate jeopardy administrative review/offsite investigation | 108 | 6% |
| Referral—immediately | 3 | <1% |
| Referral—other | 8 | <1% |
| No action necessary | 1 | <1% |

Note: Some HHAs had more than one complaint lodged against them; however, we counted each HHA only once for each complaint severity level.
Source: OIG analysis of 1,784 HHAs with complaints lodged against them in FYs 2010–11.

Surveyors conducted complaint surveys for 1,781 of the 1,784 HHAs that had one or more complaints lodged against them. For the remaining three HHAs, surveyors neither conducted nor required a complaint survey.

Surveyors found supporting evidence and substantiated at least one complaint for 47 percent of HHAs (842 of 1,784) with complaints lodged against them. Two or more complaints were substantiated for nearly 70 percent of these HHAs (586 of 842).[43] For one HHA alone, surveyors substantiated 25 complaints. The most common type of complaint, substantiated for 523 HHAs, related to quality of care and treatment of patients. (Table 3 lists the most common types of complaints lodged and substantiated against HHAs and Appendix B provides a comprehensive list of lodged and substantiated complaints.)

Of the 1,615 HHAs with complaint survey records stored in ASPEN, 7 percent (113 of 1,615) were cited with at least one condition-level deficiency.[44] Surveyors cited an additional 39 percent of HHAs

[43] Two hundred fifty-six HHAs had one substantiated complaint, 196 HHAs had 2, 164 HHAs had 3, 87 HHAs had 4, and 139 HHAs had 5 or more substantiated complaints.

[44] As previously stated, we could not include in this analysis the 261 HHAs that received a complaint survey but lacked records of the survey results in ASPEN.

(636) with standard-level deficiencies only. For the remaining 54 percent of HHAs (866), surveyors cited no deficiencies.

**Table 3: HHAs With Substantiated Complaints, by Complaint Type**

| Description of Complaint | HHAs With Complaints Lodged Against Them (n=1,784) | HHAs With Substantiated Complaints (n=842) |
|---|---|---|
| Quality of care/treatment | 1,089 | 523 |
| Administration/personnel | 665 | 312 |
| Patient rights | 622 | 250 |
| Nursing services | 370 | 156 |
| Admission, transfer, and discharge rights | 286 | 124 |
| Falsification of records/reports | 207 | 88 |
| Fraud/false billing | 175 | 72 |
| Patient neglect | 167 | 77 |

Note: Some HHAs had more than one complaint lodged against them and/or more than one substantiated complaint; however, we counted each HHA only once for each complaint description.
Source: OIG analysis of 1,784 HHAs with complaints lodged against them in FYs 2010–11.

### *With few exceptions, HHAs corrected all condition-level deficiencies cited during complaint surveys*

Surveyors placed all HHAs that were cited for a condition-level deficiency during a complaint survey on a 90-day termination track. Eighty-two percent of HHAs (93 of 113) that were cited for condition-level deficiencies corrected all deficiencies and returned to compliance within required timeframes—on average, 32 days following the complaint survey. Among the 18 percent of HHAs (20 of 113) that did not return to compliance as required, CMS terminated the Medicare participation of 9 HHAs, and another 4 HHAs voluntarily discontinued their participation. The remaining seven HHAs corrected their condition-level deficiencies after the required 90-day timeframe, returning to compliance, on average, 120 days following the complaint survey.

## State agencies conducted look-behind surveys of 14 percent of HHAs surveyed by accreditation organizations, exceeding CMS's 5-percent standard

Accreditation organizations conducted recertification surveys of 18 percent of all HHAs (1,106 of 6,316) during FYs 2010–11. To monitor accreditation organizations' performance during this time, State agencies conducted look-behind surveys of 14 percent (153) of the 1,106 HHAs surveyed by the three accreditation organizations. This exceeded CMS's 5-percent standard for look-behind surveys of HHAs surveyed by accreditation organizations. For 24 of the 153 HHAs that received a look-behind survey, State agencies identified condition-level deficiencies

that accreditation organizations missed, resulting in an overall 16-percent disparity rate.

## CMS rarely conducted look-behind surveys for oversight of State agencies' surveys of HHAs; such look-behind surveys are not required by Federal regulation

Although State agencies conduct most recertification surveys (82 percent of all HHAs during FYs 2010–11), Federal regulations do not require CMS to perform look-behind surveys to assess State agencies' survey performance. Further, during FYs 2010–11, CMS rarely conducted such surveys. Specifically, among the 5,210 HHAs that received recertification surveys from State agencies, 5 HHAs—about one-tenth of 1 percent—received a look-behind survey from CMS, with all 5 surveys occurring in FY 2010. The small number of look-behind surveys prevents any conclusion as to the usefulness of conducting such surveys. It also prevents CMS from calculating disparity rates for State agencies' surveys of HHAs and thus from using these rates to evaluate State agencies in the manner it evaluates accreditation organizations.

## CONCLUSION AND RECOMMENDATION

Over the last decade, the use of home health services increased significantly and Medicare payments for such services and the number of HHAs both more than doubled. CMS is responsible for ensuring that HHAs comply with Federal requirements and provide quality care, and CMS relies on State agencies and accreditation organizations to verify HHAs' compliance through onsite surveys and complaint investigations. Overall, we found that surveyors conducted recertification surveys and investigated complaints as required and that HHAs cited with condition-level deficiencies took corrective action during FYs 2010–11.

To assess accreditation organizations' survey performance, CMS contracted with State agencies to conduct look-behind surveys of HHAs surveyed by accreditation organizations. However, CMS is not required to conduct, and rarely conducted, similar look-behind surveys to assess State agency survey performance. Given that State agencies conducted the vast majority of HHAs' recertification surveys (82 percent in FYs 2010–11) and demonstrated wide variation in citing condition-level deficiencies, the lack of look-behind surveys for oversight of State agencies could present a vulnerability to program effectiveness and quality of care for Medicare beneficiaries. By way of comparison, CMS is required to conduct, and routinely conducts, look-behind surveys of State agency-surveyed nursing homes, which serve beneficiary populations similar to those of HHAs.

We recommend that CMS:

### Analyze Survey Data to Determine Whether It Should Routinely Conduct Look-Behind Surveys for Oversight of State Agencies

CMS should analyze existing survey data to determine whether to assess State agency survey performance and implement routine look-behind surveys of HHAs surveyed by State agencies. Conducting look-behind surveys for State agencies in the same manner as those that CMS is required to conduct for accreditation organizations would provide CMS with disparity rates for State agencies. Considering that many State agencies cited few or no condition-level deficiencies for HHAs during recertification surveys, look-behind surveys would also provide CMS with insight regarding variation among States in issuing condition-level deficiency citations.

## AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with our recommendation to analyze survey data to determine whether it should routinely conduct look-behind surveys for oversight of State agencies. CMS stated that its central office will work with the CMS regional offices to identify State agencies with the greatest need for look-behind surveys. CMS also stated that it will evaluate other oversight options to monitor State agency performance. For the full text of CMS's comments, see Appendix C.

# APPENDIX A

## The Number and Percentage of Home Health Agencies Cited With Condition-Level Deficiencies on Recertification Surveys During Fiscal Years 2010–11

**Table A-1: Home Health Agencies Cited With Condition-Level Deficiencies on Recertification Surveys Conducted by State Survey Agencies During Fiscal Years 2010–11**

| State | Home Health Agencies (HHA) Receiving a Recertification Survey (n=5,210) | HHAs Cited With Condition-Level Deficiencies (n=542) | Percentage of HHAs Cited With Condition-Level Deficiencies |
|---|---|---|---|
| U.S. Virgin Islands | 2 | 1 | 50% |
| Michigan | 64 | 31 | 48% |
| Idaho | 27 | 9 | 33% |
| Montana | 24 | 8 | 33% |
| Colorado | 86 | 25 | 29% |
| Nevada | 35 | 8 | 23% |
| California | 375 | 74 | 20% |
| Maine | 5 | 1 | 20% |
| Kansas | 98 | 15 | 15% |
| Puerto Rico | 20 | 3 | 15% |
| Arizona | 51 | 7 | 14% |
| Ohio | 308 | 42 | 14% |
| Vermont | 7 | 1 | 14% |
| Indiana | 135 | 17 | 13% |
| New Mexico | 39 | 5 | 13% |
| Alabama | 65 | 8 | 12% |
| Florida | 351 | 37 | 11% |
| Iowa | 99 | 11 | 11% |
| Texas | 1,114 | 123 | 11% |
| Connecticut | 50 | 5 | 10% |
| District of Columbia | 20 | 2 | 10% |
| New Hampshire | 20 | 2 | 10% |
| Minnesota | 131 | 12 | 9% |

continued on next page

**Table A-1: Home Health Agencies Cited With Condition-Level Deficiencies on Recertification Surveys Conducted by State Survey Agencies During Fiscal Years 2010–11 (Continued)**

| State | Home Health Agencies (HHA) Receiving a Recertification Survey (n=5,210) | HHAs Cited With Condition-Level Deficiencies (n=542) | Percentage of HHAs Cited With Condition-Level Deficiencies |
|---|---|---|---|
| New Jersey | 22 | 2 | 9% |
| Utah | 64 | 6 | 9% |
| Arkansas | 119 | 9 | 8% |
| Kentucky | 73 | 6 | 8% |
| Illinois | 287 | 21 | 7% |
| Louisiana | 105 | 7 | 7% |
| Massachusetts | 86 | 6 | 7% |
| Georgia | 64 | 4 | 6% |
| Missouri | 119 | 7 | 6% |
| Wyoming | 16 | 1 | 6% |
| Oklahoma | 108 | 5 | 5% |
| Washington | 22 | 1 | 5% |
| New York | 115 | 5 | 4% |
| Tennessee | 48 | 2 | 4% |
| West Virginia | 53 | 2 | 4% |
| South Dakota | 37 | 1 | 3% |
| Virginia | 104 | 3 | 3% |
| South Carolina | 48 | 1 | 2% |
| Wisconsin | 86 | 2 | 2% |
| North Carolina | 108 | 1 | 1% |
| Pennsylvania | 228 | 3 | 1% |
| Alaska | 11 | 0 | 0% |
| Delaware | 11 | 0 | 0% |
| Hawaii | 7 | 0 | 0% |
| Maryland | 18 | 0 | 0% |
| Mississippi | 26 | 0 | 0% |
| Nebraska | 52 | 0 | 0% |
| North Dakota | 14 | 0 | 0% |
| Oregon | 29 | 0 | 0% |
| Rhode Island | 4 | 0 | 0% |

Source: Office of Inspector General (OIG) analysis of Automated Survey Processing Environments' recertification data for fiscal years 2010–11.

**Table A-2: Home Health Agencies Cited With Condition-Level Deficiencies on Recertification Surveys Conducted by Accreditation Organizations During Fiscal Years 2010–11**

| Accreditation Organization | Home Health Agencies (HHA) Receiving a Recertification Survey (n=1,106) | HHAs Cited With Condition-Level Deficiencies (n=210) | Percentage of HHAs Cited With Condition-Level Deficiencies |
|---|---|---|---|
| The Joint Commission | 480 | 159 | 33% |
| Accreditation Commission for Health Care | 142 | 13 | 9% |
| Community Health Accreditation Program | 484 | 38 | 8% |

Note: Each accreditation organization uses its own survey instrument and methodology. Although accreditation organizations must match their deficiency citations to those used by State agencies, a deficiency cited by an accreditation organization may or may not correspond directly to a deficiency cited by a State agency.
Source: OIG analysis of recertification data from the Accrediting Organization System for Storing User Recorded Experiences for fiscal years 2010–11.

# APPENDIX B

## Types of Complaints Lodged and Substantiated Against Home Health Agencies During Fiscal Years 2010–11

| Complaint Description | Home Health Agencies (HHA) With Complaints Lodged Against Them (n=1,784) | HHAs With Substantiated Complaints (n=842) |
|---|---|---|
| Quality of care/treatment | 1,089 | 523 |
| Administration/personnel | 665 | 312 |
| Patient rights | 622 | 250 |
| Nursing services | 370 | 156 |
| Admission, transfer, and discharge rights | 286 | 124 |
| Other | 228 | 111 |
| Falsification of records/reports | 207 | 88 |
| Patient neglect | 167 | 77 |
| Fraud/false billing | 175 | 72 |
| Unqualified personnel | 136 | 71 |
| Patient assessment | 94 | 50 |
| Patient abuse | 97 | 42 |
| Misappropriation of property | 100 | 38 |
| Infection control | 57 | 26 |
| Rehabilitation services | 41 | 19 |
| Physician services | 28 | 15 |
| Other services | 32 | 11 |
| State licensure | 7 | 4 |
| Accidents | 8 | 3 |
| Quality of life | 8 | 2 |
| Physical environment | 10 | 2 |
| Pharmaceutical services | 6 | 1 |
| Death | 5 | 1 |
| Educational services | 3 | 1 |
| State monitoring | 2 | 1 |
| Restraints/seclusion—general | 1 | 1 |
| No classification given | 8 | 0 |
| Injury of unknown origin | 5 | 0 |

Note: Some complaints had more than one description and some HHAs had more than one complaint; however, we counted each HHA only once for each complaint description.
Source: Office of Inspector General analysis of complaints data from Automated Survey Processing Environments for fiscal years 2010-11.

# APPENDIX C

## Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

*Administrator*
Washington, DC 20201

**DATE:** MAR 0 5 2013

**TO:** Daniel R. Levinson
Inspector General

**FROM:** Marilyn Tavenner
Acting Administrator

**SUBJECT:** Office of Inspector General (OIG) Draft Report: *Home Health Agencies Received Timely Surveys and Corrected Deficiencies as Required* (OEI-06-11-00400)

Thank you for the opportunity to review and comment on the above subject draft report. The Centers for Medicare & Medicaid Services (CMS) appreciates the extensive work done by OIG staff in the development of the report. CMS is dedicated to its responsibility to oversee the surveys of home health agencies (HHAs) on a timely basis and making sure all deficiencies are corrected in order to protect the beneficiaries served by these providers. Surveys of HHAs are conducted by both state agencies and approved Accrediting Organizations (AOs). Surveys include initial certifications, recertification and complaint surveys as well as validation surveys of AOs. CMS recognizes the growth of HHAs and the risks posed to the Medicare program and the importance of compliance with CMS requirements. The OIG's objectives for this study are to determine the extent to which: (1) state survey agencies and accreditation organizations conducted recertification surveys of HHAs within required timeframes during fiscal years (FYs) 2010-11; (2) HHAs received deficiency citations on recertification surveys and the nature and resulting actions of those deficiencies during FYs 2010-11; (3) HHAs had complaints lodged (i.e., allegations made) against them, the nature of those complaints, and the actions resulting from those complaints during FYs 2010-11; and (4) CMS used "look-behind" surveys to assess the performance of surveyors during FYs 2010-11.

The OIG recommendation and CMS response are discussed below.

**OIG Recommendation**

The OIG recommends that CMS analyze survey data to determine whether it should routinely conduct look-behind surveys for oversight of state agencies.

**CMS Response**

The CMS concurs with this recommendation. CMS is striving to strengthen our reviews of HHAs in a variety of ways. An increase in HHA look-behind survey activity would be an effective tool in this effort. While look-behind activity in HHAs is not statutorily based, CMS's central office will work with our regional offices to develop criteria that will target the need for HHA look behind activity in a particular state agency based upon the agency's survey reports, to the extent possible within existing fiscal constraints. CMS will also evaluate a variety of other options to assure effective look-behind oversight of SA performance.

The CMS looks forward to working with OIG on this and other issues in the future.

## ACKNOWLEDGMENTS

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