

EXAMINING FEDERAL EFFORTS TO ENSURE
QUALITY OF CARE AND RESIDENT SAFETY
IN NURSING HOMES

HEARING
BEFORE THE
SUBCOMMITTEE ON OVERSIGHT AND
INVESTIGATIONS
OF THE
COMMITTEE ON ENERGY AND
COMMERCE
HOUSE OF REPRESENTATIVES
ONE HUNDRED FIFTEENTH CONGRESS
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¹ The information can be found at: <https://docs.house.gov/meetings/IF/IF02/20180906/108648/HHRG-115-IF02-20180906-SD003.pdf>.

EXAMINING FEDERAL EFFORTS TO ENSURE QUALITY OF CARE AND RESIDENT SAFETY IN NURSING HOMES

THURSDAY, SEPTEMBER 6, 2018

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:15 a.m., in room 2322 Rayburn House Office Building, Hon. Gregg Harper (chairman of the subcommittee) presiding.

Members present: Representatives Harper, Griffith, Burgess, Brooks, Walberg, Walters, Costello, Carter, Walden (ex officio), DeGette, Schakowsky, Castor, Clarke, Ruiz, and Pallone (ex officio).

Also present: Representative Bilirakis.

Staff present: Jennifer Barblan, Chief Counsel, Oversight and Investigations; Samantha Bopp, Staff Assistant; Lamar Echols, Counsel, Oversight and Investigations; Ali Fulling, Legislative Clerk, Oversight and Investigations, Digital Commerce and Consumer Protection; Christopher Santini, Counsel, Oversight and Investigations; Jennifer Sherman, Press Secretary; Julie Babayan, Minority Counsel; Jeff Carroll, Minority Staff Director; Tiffany Guarascio, Minority Deputy Staff Director and Chief Health Advisor; Chris Knauer, Minority Oversight Staff Director; Jourdan Lewis, Minority Staff Assistant and Policy Analyst; Kevin McAloon, Minority Professional Staff Member; and C.J. Young, Minority Press Secretary.

OPENING STATEMENT OF HON. GREGG HARPER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MISSISSIPPI

Mr. HARPER. We will call to order today's subcommittee hearing, Oversight and Investigations, and our hearing today is on Examining Federal Efforts to Ensure Quality of Care and Resident Safety in Nursing Homes. I want to welcome each of our witnesses that are here today, and at this point I am going to recognize myself for our opening statement.

So this a very important subject and the subcommittee continues to work in examining whether the Federal Government is meeting its obligations to ensure that residents in nursing homes across the country are free from abuse and receiving the quality of care that they deserve and respect. Protecting our most vulnerable citizens

is among the most fundamental responsibilities entrusted to the Federal Government and it is also a responsibility that we as Americans all share.

The Centers for Medicare and Medicaid Services, CMS, is the Federal agency tasked with ensuring nursing home residents are protected and well cared for, and CMS largely relies on the efforts of State survey agencies to verify that nursing homes are meeting Federal standards for quality and safety.

However, reports issued by the Department of Health and Human Services Office of Inspector General and the Government Accountability Office, along with all too frequent press reports, detail horrible cases of abuse and neglect occurring in nursing homes raises questions as to whether CMS is fulfilling its obligations to residents. For example, in 2014, OIG found that based on its review of more than 650 medical records of Medicare beneficiaries that were receiving care in a nursing home, approximately one-third of residents experienced some type of harm during their stay. According to OIG, nearly 60 percent of this harm was either clearly preventable or likely preventable.

Last year, reports emerged out of Florida of the deaths of at least a dozen residents of the Rehabilitation Center at Hollywood Hills after the facility's air conditioning system failed in the immediate aftermath of Hurricane Irma. According to state regulators, temperatures at the facility reached nearly a hundred degrees and the facility deprived residents of timely medical care despite being located across the street from a fully functioning and functional hospital.

CMS described the events at this nursing home as a complete management failure and terminated the facility from the Medicare and Medicaid programs noting that the conditions at the facility constituted an immediate jeopardy to residents' health and safety. Previously, this facility's owner entered into a settlement agreement with the Federal Government to resolve allegations he and his associates had paid kickbacks and performed medically unnecessary treatments to generate Medicare and Medicaid payments at another Florida healthcare facility in which he had an ownership interest. Despite this history and last year's tragedy at that person's rehabilitation center, we have learned that the facility's owner continues to maintain an ownership interest in at least 11 facilities participating in the Medicare and Medicaid programs.

It can't be emphasized enough that it should not take a tragedy like what we have seen at the Rehabilitation Center at Hollywood Hills to make CMS mindful or take action in response of conditions at nursing homes that threaten residents' well-being. However, the committee's oversight and reports issued by OIG and GAO suggest that this isn't necessarily the case.

Improving care for vulnerable populations including the care provided to nursing home residents has been identified by OIG as a top management challenge for over a decade. We want to know why this continues to be a top management challenge, what steps CMS is taking to improve efforts to enforce existing regulatory requirements, and how the agency is addressing any gaps in its oversight.

At the same time, we want to recognize the many, and I mean many, nursing homes that are providing their residents with high quality care. In advance of this hearing I checked in with Vanessa Henderson, Executive Director for the Mississippi Health Care Association, for an update on our facilities after Tropical Storm Gordon made landfall late last night on the Mississippi Gulf Coast. Ms. Henderson received reports every 2 hours throughout the night from 19 nursing homes in nine South Mississippi counties. There were no major issues. They were well prepared.

When Hurricane Katrina devastated the Mississippi Gulf Coast, now 13 years ago, there was no fatality or major problem at a nursing home in Mississippi. And I am proud of these successes in my home State. What are the best practices being utilized at these facilities that if applied everywhere could yield positive outcomes for nursing home residents?

I look forward to hearing from each member on our panel on ways we can improve our Federal oversight of nursing homes to ensure that CMS is protecting seniors from abuse and neglect in nursing homes and using its authority in a fair and efficient manner. I thank you for your testimony today and I now recognize the ranking member of the subcommittee from Colorado, Ms. DeGette, for 5 minutes.

[The prepared statement of Mr. Harper follows:]

PREPARED STATEMENT OF HON. GREGG HARPER

Good morning, today the Subcommittee continues its work examining whether the Federal Government is meeting its obligations to ensure that residents in nursing homes across the country are free from abuse and are receiving the quality of care they deserve. Protecting our most vulnerable citizens is among the most fundamental responsibilities entrusted to the Federal Government, and it is also a responsibility that we, as Americans, all share.

The Centers for Medicare and Medicaid Services (CMS) is the Federal agency tasked with ensuring nursing home residents are protected and well-cared for, and CMS largely relies on the efforts of state survey agencies to verify that nursing homes are meeting Federal standards for quality and safety. However, reports issued by the Department of Health and Human Services' Office of Inspector General (OIG) and the Government Accountability Office (GAO), along with all too frequent press reports that detail horrible cases of abuse and neglect occurring in nursing homes, raise questions as to whether CMS is fulfilling its obligations to residents.

For example, in 2014 OIG found that, based on its review of more than 650 medical records of Medicare beneficiaries that were receiving care in a nursing home, approximately one-third of residents experienced some type of harm during their stay. According to OIG, nearly 60 percent of this harm was either clearly preventable or likely preventable.

Last year, reports emerged out of Florida of the deaths of at least a dozen residents of the Rehabilitation Center at Hollywood Hills after the facility's air conditioning system failed in the immediate aftermath of Hurricane Irma. According to state regulators, temperatures at the facility reached nearly 100 degrees and the facility deprived residents of timely medical care despite being located across the street from a fully-functional hospital. CMS described the events at this nursing home as a "complete management failure" and terminated the facility from the Medicare and Medicaid programs, noting the conditions at the facility constituted an immediate jeopardy to residents' health and safety.

Previously, the facility's owner entered into a settlement agreement with the federal government to resolve allegations he and his associates paid kickbacks and performed medically unnecessary treatments to generate Medicare and Medicaid payments at another Florida health care facility in which he had an ownership interest.

Despite this history, and last year's tragedy at the Rehabilitation Center, we have learned that the facility's owner continues to maintain an ownership interest in at least 11 facilities participating in the Medicare and Medicaid programs.

It can't be emphasized enough that it should not take a tragedy like what was seen at the Rehabilitation Center at Hollywood Hills to make CMS mindful, or take action in response, of conditions at nursing homes that threaten residents' well-being. However, the Committee's oversight, and reports issued by OIG and GAO, suggest that this isn't necessarily the case. Improving care for vulnerable populations, including the care provided to nursing home residents, has been identified by OIG as a top management challenge for over a decade. We want to know why this continues to be a top management challenge, what steps CMS is taking to improve efforts to enforce existing regulatory requirements, and how the agency is addressing any gaps in its oversight.

We also want to recognize the many nursing homes that are providing their residents with high quality care. In advance of this hearing, I checked in with Vanessa Henderson, Executive Director for the Mississippi Health Care Association, for an update on our facilities after Tropical Storm Gordon made landfall late last night on the Mississippi Gulf Coast.

Ms. Henderson received reports every two hours throughout the night from 19 nursing homes in 9 south Mississippi counties. There were no major issues. When Hurricane Katrina devastated the Mississippi Gulf Coast 13 years ago there was no fatality or major problem at a nursing home in Mississippi. I am proud of these successes in my home state. What are the best practices being utilized at these facilities that if applied elsewhere could yield positive outcomes for nursing home residents?

I look forward to hearing from each member of our panel on ways we can improve our Federal oversight of nursing homes to ensure that CMS is protecting seniors from abuse and neglect in nursing homes and using its authorities in a fair and effective manner. I thank you for your testimony today and now recognize the Ranking Member of the Subcommittee from Colorado, Ms. DeGette, for 5 minutes.

OPENING STATEMENT OF HON. DIANA DEGETTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

Ms. DEGETTE. Thank you so much, Mr. Chairman. I guess as proof that this subcommittee often, most often, works in a bipartisan way, my opening statement is pretty much exactly the same opening statement you just made down to the example of the Hollywood Hills tragedy after Hurricane Irma when 14 people died. So I am going to submit my written statement for the record, I just want to make a couple of observations.

The first one is some of us have been on this subcommittee for many, many years and those of you who have been here you know that for all of these years we have struggled to address the issue of quality care at nursing homes. Both the IG at HHS and also the GAO have consistently raised issues over the years about how the States and CMS oversee the nursing home industry and every so often we have a real tragedy like this Hollywood Hills tragedy.

But then, you have got to wonder how many more facilities are like this and what are we doing to make a permanent effort. It just seems like we haven't turned the corner to get where we need to be in providing effective oversight in this sector of care. For example, just today, the Inspector General in written testimony mentions a statistic that I find really troubling. Fully one-third of Medicare residents in a skilled nursing home experienced harm from the care that they received and half of those cases were actually preventable.

So we do this over and over again, but yet, one-third of Medicare residents have experienced harm. Now the IG has made recommendations for how to improve these issues. CMS needs to articulate to us today what concrete steps the agency is making to improve this. I also want to know what progress CMS is making

on implementing the updated health and safety regulations that were finalized in 2016 after a lengthy rulemaking process.

It took years and a lot of public feedback, but in 2016 CMS did update the federal nursing home regulations to improve planning for resident care, training for staff, and protections against abuse, among other issues. But now as CMS is implementing these new rules, the agency has taken a series of actions that have led consumer groups, state attorneys general, and others to question whether CMS is doing enough to strengthen and enforce federal standards.

Here is a couple of examples: Last year CMS announced that it had imposed a moratorium on the enforcement of many of these regulations. In other words the agency is restraining itself from using some of its most effective enforcement tools against those who violate those new rules designed to protect vulnerable nursing home residents.

I must say CMS has to commit itself to implementing and enforcing its own regulations. That sounds kind of like a ridiculous thing to say but it is true, because as I said the core issue is here that frail and vulnerable people are harmed when nursing homes fail to meet our standards. And I don't think any of us wants to wait until the next natural disaster or other disaster exposes some kind of a deficiency that kills dozens of people.

I want to thank the witnesses for being here today. I want to thank the Inspector General and the GAO for your body of oversight of work on nursing homes, and I hope that we won't be back here again next year or in 5 years to talk about how more people have died. Thanks, and I yield back.

Mr. HARPER. The gentlewoman yields back.

The chair will now recognize the gentleman from Oregon, the chairman of the full committee, Mr. Walden, for 5 minutes.

OPENING STATEMENT OF HON. GREG WALDEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OREGON

Mr. WALDEN. Thank you very much, Mr. Chairman. Thanks for holding this hearing on this topic that is very important to all of us across the country.

I think it is important to put it all in context as well. According to information released by the Centers for Medicare and Medicaid Services, more than three million individuals rely on services provided by nursing homes at some point during every year. And on any given day, 1.4 million Americans reside in more than 15,000 nursing homes across our country and the overwhelming majority of these nursing homes provide high quality, lifesaving care to their residents. We know that too.

I have heard from many seniors and their families in my district about how they or their loved ones are receiving excellent, around-the-clock care at their nursing homes and they go above and beyond. One provider I spoke with recently has a facility down in Redding, California. And when the fires were threatening Redding he chartered buses, had them on the ready with 200 seats, made arrangements, and all of this was happening very, very quickly to be able to move patients, residents to a facility many miles away in Klamath Falls, Oregon, if need be. As it turned out he didn't

have to do that evacuation, but they were ready. Unfortunately, this doesn't appear to be the case in all nursing homes.

We all know the discussion that has occurred around what happened at the Rehabilitation Center at Hollywood Hills, Florida, run by Dr. Jack Michel. That tragedy that occurred at that facility during Hurricane Irma was the result of inexcusable management or mismanagement and it resulted in needless loss of life.

While many facilities in Florida had the right procedures in place and handled the hurricanes well, we need to make sure our Federal oversight efforts are effective in detecting low quality, unsafe nursing homes while being mindful to not impose excessive regulatory burdens that in some cases don't help but cost a lot of money and tie up resources. So I think we need to look at that as well, what is working and what is not, to get to the underlying problems we have identified in the OIG and others have.

As Chairman Harper described, CMS is the Federal agency responsible for ensuring the safety and quality of care provided to Medicare and Medicaid beneficiaries in nursing homes. CMS enters into these agreements with the states providing that state agencies will inspect nursing homes on CMS' behalf to determine whether the facilities are meeting Federal requirements.

And so this is done by the states. However, CMS may not always be effectively overseeing that work that these agencies do on behalf of the federal government. Over the last decade or so, the Department of Health and Human Services Office of Inspector General and Government Accountability Office have both issued reports indicating CMS could improve its oversight of nursing homes.

For example, HHS OIG has examined whether States properly verify that deficiencies identified during nursing home inspections are corrected. In some instances, such as my State of Oregon, HHS OIG found the State properly verified that facilities corrected deficiencies after they were identified and during inspections.

Several of the reports on this topic, however, HHS OIG has found that state agencies elsewhere did not meet that standard of proper oversight. For example, a report issued this May estimated that in 2016 Nebraska failed to properly verify that deficiencies at nursing homes identified during state inspections were corrected 92 percent of the time. CMS needs to ensure that all state survey agencies are adequately conducting the survey process on their behalf.

We are looking forward to hearing what CMS is doing to improve its oversight of the survey process. We also look forward to hearing from GAO about their work and recommendations, especially their recommendations relating to CMS' oversight of state survey agencies. So the focus of today's hearing is to learn more about what CMS is doing to maintain consistency across the country and guarantee that all States are effectively surveying nursing homes on their behalf to ensure compliance with existing Federal requirements.

We also want to know what we can do to help in these efforts. So it is important that CMS effectively enforce existing requirements for nursing homes to protect and promote safety, especially in extreme cases like what happened at the Rehabilitation Center at Hollywood Hills. And lastly, I want to thank our witnesses for

being a part of this important conversation. We very much value and appreciate your testimony.

With that Mr. Chair, unless anyone else wants the remainder—Dr. Burgess chairs our Subcommittee on Health—I yield the balance to you.

[The prepared statement of Mr. Walden follows:]

PREPARED STATEMENT OF HON. GREG WALDEN

Thank you, Mr. Chairman, for holding this hearing on the very important issue of protecting one of the most vulnerable populations in the United States—the elderly.

According to information released by the Centers for Medicare and Medicaid Services (CMS), more than 3 million individuals rely on services provided by nursing homes at some point during the year. On any given day, 1.4 million Americans reside in the more than 15,000 nursing homes across our country. The overwhelming majority of these nursing homes provide high quality, life-saving care to their residents.

I've heard from many seniors and their families in my district about how they or their loved ones are receiving excellent, around the clock care at their nursing homes. And many go above and beyond.

One provider I spoke with recently has a facility in Redding, California, and set a good example of what to strive for in preparing for an emergency, with 200 seats on buses ready to go at a moment's notice, and agreements with providers in Klamath Falls, Oregon to house their patients if this summer's devastating wildfires threatened their facility.

Unfortunately, this doesn't appear to be the case in all nursing homes across the country, such as the Rehabilitation Center in Hollywood Hills, Florida, run by Dr. Jack Michel. The tragedy that occurred at this facility during Hurricane Irma was a result of inexcusable management, and it resulted in needless loss of life. While many facilities in Florida had the right procedures in place and handled the hurricanes well, we need to make sure our federal oversight efforts are effective in detecting low quality, unsafe nursing homes while being mindful to not to impose excessive regulatory burdens that, in some cases, may actually hinder resident care.

As Chairman Harper described, CMS is the Federal agency responsible for ensuring the safety and quality of care provided to Medicare and Medicaid beneficiaries in nursing homes. CMS enters into agreements with individual states, providing that state agencies will inspect nursing homes on CMS' behalf to determine whether the facilities in a particular State meet Federal requirements to participate in these programs.

However, CMS may not always be effectively overseeing the work that these state agencies are doing on its behalf. Over the last decade or so, the Department of Health and Human Services' (HHS) Office of Inspector General (OIG) and the Government Accountability Office (GAO) have both issued reports indicating that CMS could improve its oversight of nursing homes.

For example, HHS OIG has examined whether states properly verify that deficiencies identified during nursing home inspections are corrected. In some instances, such as my home State of Oregon, HHS OIG has found that the State properly verified that facilities corrected deficiencies after they were identified during inspections. In several of the reports on this topic, however, HHS OIG has found that state agencies did not meet that standard of proper oversight. For example, a report issued this past May, estimated that in 2016 Nebraska failed to properly verify that deficiencies at nursing homes identified during state inspections were corrected 92 percent of the time. CMS needs to ensure that all state survey agencies are adequately conducting the survey process on their behalf. We are looking forward to hearing what CMS is doing to improve its oversight of the survey process.

We also look forward to hearing from GAO about their work and recommendations—especially their recommendations relating to CMS' oversight of state survey agencies.

The focus of today's hearing is to learn more about what CMS is doing to maintain consistency across the country and guarantee that all States are effectively surveying nursing homes on their behalf to ensure compliance with existing federal requirements. We also want to know what we can do to help these efforts.

It is important that CMS effectively enforce existing requirements for nursing homes to protect and promote patient safety, especially in extreme cases like what happened at the Rehabilitation Center at Hollywood Hills. Lastly, I'd like to thank

our witnesses for being a part of this important conversation and look forward to their testimony.

Mr. BURGESS. Well, thank you, Chairman Walden.

And I just want to mention that like Representative DeGette, in January of 2006 this subcommittee held a hearing, field hearing, in New Orleans, Louisiana, dealing with just this issue. So this morning it is important to see not just one of the lessons learned but how it is the implementation of those lessons and how really report not just to us, on us, how we are doing in overseeing the oversight that the agency is supposed to provide to the facilities that are taking care of our seniors.

So thank you, Mr. Chairman, for doing this hearing and I will yield back.

Mr. HARPER. The gentleman yields back.

The chair will now recognize the ranking member of the full committee, Mr. Pallone, for 5 minutes.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Mr. Chairman. Nursing home residents are among our most vulnerable populations who are often unable to care for themselves and require personal attention. Many of us have had loved ones in the care of nursing homes or skilled nursing facilities so we can all appreciate the need to ensure these facilities are providing high quality care. Most of the time nursing homes are staffed by compassionate professionals who want to provide quality care to those who need it and these professionals are strong allies too in our efforts to ensure residents are properly taken care of.

As the Department of Health and Human Services Office of Inspector General points out in his testimony today, nursing homes offer enormous benefit by providing a place of comfort and healing to residents in fragile health, many of whom are insured by Medicaid. The best nursing homes provide excellent care and take seriously their duty to protect their residents.

That said, nursing home quality of care is a longstanding concern and we should always strive to conduct oversight of this sector in an effort to improve the overall quality of care. And over the past several years, HHS's OIG and the Government Accountability Office have both found problems in nursing home delivery of care and Federal and State oversight. And that is not to say that we should be suspicious of all nursing homes, rather, certain providers have failed to ensure high quality care.

For example, OIG has found that when incidents of abuse or neglect occur some nursing homes fail to report them as required and GAO has identified gaps in nursing homes' emergency preparedness and response capabilities. We can and must demand better for our loved ones and that is why we must focus our resources to weed out these bad actors so that residents are protected and the rest of the industry is not given a black eye.

And that is where the Centers for Medicare and Medicaid Services comes in. In exchange for participating in the Medicare/Medicaid programs, nursing homes must comply with Federal stand-

ards related to health and safety. CMS is charged with overseeing nursing homes' compliance with those standards and the agency has enforcement mechanisms at its disposal. And among those standards are the ability to terminate a facility participation in Medicare and Medicaid if it does not comply, however, OIG and GAO have long raised questions about CMS' oversight of nursing homes.

For instance, OIG notes that CMS does not always ensure that abuse and neglect at skilled nursing facilities are identified and reported, and when a nursing home is cited for deficiency OIG has found that CMS does not always require them to correct the problem. Many of these same issues have been raised for several years so the committee needs to hear what progress CMS is making and what more needs to be done to better ensure quality of care.

CMS also relies on state survey agencies to conduct inspections of nursing homes on CMS' behalf, but some States have been better than others at ensuring high quality care. OIG's audits have revealed that several States fell short in investigating the most serious complaints and many had difficulty meeting CMS' standards. Workforce shortages and inexperienced surveyors at the state level have also led to the understatement of serious care problems. And, hereto, OIG and GAO have found problems with CMS' oversight of the state agencies. We need to hear what CMS needs to do better or differently to ensure Federal requirements are being followed.

And, finally, CMS has yet to finalize and enforce some 2016 regulations to update and strengthen the nursing home standards. These regulations address critical areas such as staff training and protections against abuse, among other issues. However, last year, CMS issued a moratorium on enforcement of many of these regulations. And it is important to hear the input of industry and consumer groups to ensure regulations are done right, but without actually enforcing these rules it is unclear how CMS will ensure the quality and safety of our nation's nursing homes.

So Dr. Goodrich needs to articulate today how CMS is considering the concerns of the industry and consumers while also meeting its responsibility to ensure high quality care in nursing homes. I yield back, Mr., I mean unless anybody else wants the time, but I don't think so. I yield back.

Mr. HARPER. The gentleman yields back. I ask unanimous consent that the members' written opening statements be made part of the record. Without objection, they will so be entered into the record. I also ask unanimous consent that members of the full committee on Energy and Commerce not on this subcommittee be permitted to participate in today's hearing.

I would now like to introduce our witnesses for today's hearing. Today we have Dr. Kate Goodrich, the Director of the Center for Clinical Standards and Quality, and Chief Medical Officer at the Centers for Medicare and Medicaid Services. We welcome you today.

Next is Ms. Ruth Ann Dorrill, Regional Inspector General at the Office of Inspector General at the U.S. Department of Health and Human Services. Thank you for being here today.

And, finally, Mr. John Dicken, Director of Health Care at the U.S. Government Accountability Office.

You are each aware that this committee is holding an investigative hearing and when doing so has had the practice of taking testimony under oath. Do you have any objection to testifying under oath?

Let the record reflect that all three have indicated no. The chair then advises you that under the rules of the House and the rules of the committee you are entitled to be accompanied by counsel. Do you desire to be accompanied by counsel during your testimony today?

All of the witnesses have indicated no.

In that case if you would please stand and raise your right hand, I will swear you in.

[Witnesses sworn.]

Mr. HARPER. Thank you. You may be seated. You are now under oath and subject to the penalties set forth in Title 18 Section 1001 of the United States Code. You may now give a 5-minute summary of your written testimony.

And we will begin with you, Dr. Goodrich, and you are recognized for 5. We would ask that you pull the microphone a little closer to you and make sure that the mic is on. And you know the light system is such when it gets to yellow you have 1 minute. Red, the floor will not open up, but do bring it in for a landing, OK. Thank you.

You may begin.

STATEMENT OF KATE GOODRICH, M.D., DIRECTOR, CENTER FOR CLINICAL STANDARDS AND QUALITY, AND CHIEF MEDICAL OFFICER, CENTERS FOR MEDICARE & MEDICAID SERVICES; RUTH ANN DORRILL, REGIONAL INSPECTOR GENERAL, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; AND, JOHN DICKEN, DIRECTOR, HEALTH CARE, GOVERNMENT ACCOUNTABILITY OFFICE

STATEMENT OF KATE GOODRICH

Dr. GOODRICH. All right. To Chairman Harper, Ranking Member DeGette, and members of the subcommittee, thank you for the opportunity to discuss CMS' efforts to oversee nursing homes.

Resident safety is our top priority in nursing homes and all facilities that participate in the Medicare and Medicaid programs. Every nursing home must keep its residents safe and provide high quality care. Monitoring patient safety and quality of care in nursing homes requires coordinated efforts between the Federal Government and the States.

To participate in Medicare or Medicaid, a nursing home must be certified as meeting numerous statutory and regulatory requirements including those pertaining the health, safety and quality. Compliance with these requirements for participation is verified through annual unannounced, onsite surveys conducted by state survey agencies in each of the 50 States, the District of Columbia, and the U.S. territories. When a state surveyor finds a serious violation of Federal regulation they report it to CMS and swift action is taken.

In cases of immediate jeopardy, meaning a facility's noncompliance has caused or is likely to cause serious injury, harm, or even death we can terminate the facility's participation agreement within as little as 2 days. Civil monetary penalties can also be assessed up to approximately \$20,000 per day or per instance until substantial compliance is achieved. Other remedies could include in-service training or denial of payments.

For deficiencies that do not constitute immediate jeopardy, these deficiencies must be corrected within 6 months or the facility will be terminated from the program. Facilities are also required by law to report any allegation of abuse or neglect to their state survey agency and other appropriate authorities such as law enforcement or adult protective services.

When CMS learns that a nursing home has failed to report or investigate instances of abuse we take immediate action. For example, CMS issued a civil monetary penalty of almost \$350,000 to one nursing home when a state surveyor found they did not properly investigate or prevent additional abuse involving eight residents.

We are always taking steps to enhance our quality and safety oversight efforts. Last fall, surveyors began verifying facility compliance with CMS' updated and improved emergency preparedness requirements. Facilities are now required to address location-specific hazards and responses, must have emergency or standby power systems and ensure they are operational during an emergency, develop additional staff training, and implement a communications system to contact necessary persons regarding resident care and health status in a timely manner.

In addition, in 2016, CMS updated the nursing home requirements to reflect the substantial advances into theory and practice of service delivery that have been made since 1991 such as ensuring that nursing home staff are properly trained in caring for residents with dementia. Given the number of revisions, CMS has provided a phased-in approach for facilities to meet these new requirements. We are in the second of three implementation phases and we are taking a thoughtful approach to implementation and providing education to providers while holding them accountable for any deficiencies.

Promoting transparency is another key factor to incentivizing quality. By using a five-star quality rating system, our Nursing Home Compare website provides residents and their families with an easy way to understand meaningful distinctions between high and low performing facilities on three factors: health inspections, quality measures, and staffing. In April of this year, we took steps to make staffing data more accurate. The new payroll-based journal data provide unprecedented insight into how facilities are staffed which can be used to analyze how facility staffing relates to quality and patient outcomes.

Under the new systems, facilities reporting 7 or more days in a quarter with no registered nurse hours or whose audits identify significant inaccuracies between the hours reported and the hours verified will receive a one-star staffing rating which will reduce the facility's overall rating by one star.

CMS greatly appreciates and relies on the work of the Government Accountability Office and the HHS Office of the Inspector

General to inform our efforts. We have implemented a number of recommendations in this area and we look forward to additional recommendations to help us continuously improve our programs.

For example, CMS implemented a new survey process last fall that provides standardization and structure to help ensure consistency between surveyors while allowing surveyors the autonomy to make decisions based upon their expertise and judgment. We expect every nursing home to keep its residents safe and provide high quality care. As a practicing physician that makes rounds in the hospital on weekends, many of my patients are frail, elderly nursing home residents, so I am personally deeply committed to the care of these patients.

CMS remains diligent in its duties to monitor nursing homes participating in the Medicare and Medicaid programs across the country and we look forward to continuing to work with Congress, States, facilities, residents, and other stakeholders to make sure the residents we serve are receiving safe and high quality care. I look forward to answering questions you may have. Thank you.

[The prepared statement of Dr. Goodrich follows:]

**STATEMENT OF
KATE GOODRICH, M.D.,
DIRECTOR,
CENTER FOR CLINICAL STANDARDS AND QUALITY, AND
CHIEF MEDICAL OFFICER,
CENTERS FOR MEDICARE & MEDICAID SERVICES**

ON

**“EXAMING FEDERAL EFFORTS TO ENSURE QUALITY OF CARE AND
RESIDENT SAFETY IN NURSING HOMES”**

**BEFORE THE
U. S. HOUSE ENERGY AND COMMERCE COMMITTEE,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS**

SEPTEMBER 6, 2018

**U. S. House Energy and Commerce Committee,
Subcommittee on Oversight and Investigations
“Examining Federal Efforts to Ensure Quality of Care
and Resident Safety in Nursing Homes”
September 6, 2018**

Chairman Harper, Ranking Member DeGette, and members of the Subcommittee, thank you for the invitation and the opportunity to discuss efforts at the Centers for Medicare & Medicaid Services (CMS) to oversee nursing homes. Resident safety is our top priority. It is the duty of every nursing home serving Medicare and Medicaid residents to keep its residents safe and provide high quality care.

Monitoring patient safety and quality of care in nursing homes serving Medicare and Medicaid beneficiaries requires coordinated efforts between the federal government and the states. To qualify for payment for services to beneficiaries, a nursing home must be enrolled in and certified by CMS as a skilled nursing facility under the Medicare program or a nursing facility under the Medicaid program. States play a critical role in helping CMS survey for facility compliance with both federal and state requirements, such as licensure.

To become certified as a Medicare and Medicaid participating provider of services, a nursing home must meet federal statutory and regulatory requirements which include a list of specific requirements for participation pertaining to health, safety and quality.¹ Compliance with these requirements for participation is verified through unannounced on-site surveys. Nursing homes must remain in substantial compliance with these requirements, as well as state law, to continue as a Medicare or Medicaid participating provider. Our efforts are informed and improved by the work of the Government Accountability Office (GAO) and the Department of Health and Human Services Office of Inspector General (HHS-OIG), and we greatly appreciate their recommendations and ongoing assistance to ensure resident safety and facility compliance.

In addition to these quality and safety oversight efforts, CMS has made improving the quality of care provided in nursing homes and providing information to consumers about nursing home

¹ Sections 1819 and 1919 of the Social Security Act and 42 C.F.R. Parts 483 and 489.

quality a top priority. For example, in response to quality and safety concerns related to the use of antipsychotic medications among a growing number of residents with dementia, CMS launched the National Partnership to Improve Dementia Care in Nursing Homes, which has worked to optimize the quality of care and quality of life for residents in America's nursing homes by improving care for all residents, especially those with dementia, by reducing the use of antipsychotic medications and enhancing the use of nonpharmacologic approaches and person-centered dementia care practices. The CMS Nursing Home Compare² website provides detailed information for comparison of nursing homes and features a Five-Star Quality Rating System to help consumers, their families, and caregivers compare nursing homes more easily. At the direction of Administrator Seema Verma, CMS has been working tirelessly to evaluate and streamline regulations and operations with the goal to reduce unnecessary burden, increase efficiencies, and improve the customer experience for nursing facilities so that the priority is the care of the patient.

Quality and Safety Oversight

CMS works with state survey agencies in each of the 50 states, the District of Columbia, Puerto Rico, and other U.S. territories to perform surveys of providers and suppliers. For nursing homes, state survey agencies inspect these providers for compliance with Medicare and Medicaid health and safety standards related to both delivery and monitoring of care, as well as Life Safety Code requirements intended to protect residents by providing a reasonable degree of safety from fire. The states also take intake of complaints and conduct investigations accordingly.

Facilities must meet state licensure requirements, in addition to CMS statutory and regulatory requirements, to be certified as a Medicare and Medicaid provider. The state survey agency, working on behalf of CMS, is usually the same agency responsible for both state licensure and Federal surveys and oversight. Therefore, these on-site surveys are often performed by the same state team at the same time, with the findings entered into two separate survey reports: one for state licensure purposes and one for Medicare and Medicaid compliance purposes. Utilizing the expertise of state officials to perform surveys means that state agencies and officials have up-to-

² Available at: <https://www.medicare.gov/nursinghomecompare/search.html>

date information on health and safety risks at facilities, and, as appropriate, can take direct action against facilities through state licensure sanction as well as recommend federal enforcement actions and remedies in response to deficiencies with health and safety requirements.

CMS is always looking for ways to improve our quality and safety oversight efforts to safeguard nursing home residents. CMS recently updated and improved the emergency preparedness requirements for nursing homes and other providers participating in Medicare and Medicaid.³ For example, we clarified that certified nursing homes must have emergency electrical power systems for lighting entrances and doorways and maintaining fire detection, alarm, extinguishing systems as well as life support systems, must have emergency and stand-by-power systems and have a plan for ensuring these systems are operational during an emergency, and introduced additional testing requirements for these emergency and stand-by-power systems. In addition, we required facilities to develop an emergency preparedness training and testing program for new and existing staff, contracted service providers, and volunteers, as well as periodic refresher training. Facilities were required to comply with the new emergency preparedness on November 15, 2016, and surveys to evaluate compliance with the new requirements began on November 15, 2017.

CMS also made revisions to the other nursing home requirements in late 2016. These changes reflect the first comprehensive review and update of the regulations since 1991. These updated regulations reflect the substantial advances that have been made over the past several years in theory and practice of service delivery and safety and address important public health priorities such as combatting multi-drug resistant organisms among this vulnerable population. The changes made to the regulations include ensuring nursing home staff are properly trained on caring for residents with dementia and in preventing elder abuse, facilities take into consideration the health of residents when making decisions on the kinds and level of staffing a facility needs, staff have the right skills and competencies to provide person-centered care, resident's care plans take into consideration goals of cares and preferences, improvements to care planning including discharge planning, allowing dietitians and therapy providers the authority to write orders when

³ <https://www.federalregister.gov/documents/2016/09/16/2016-21404/medicare-and-medicaid-programs-emergency-preparedness-requirements-for-medicare-and-medicaid>

delegated by a physician and state licensing laws allow, and updating the infection and control program including requiring an infection prevention and control officer and an antibiotic stewardship program. These revisions are also an integral part of our efforts to achieve broad improvements both in the quality of health care furnished through federal programs, and in patient safety, while at the same time reducing procedural burdens on providers.

Given the number of revised and new requirements in this rule, CMS is implementing it in three phases. The three phases were determined based on complexity of the revisions and the work necessary to revise the interpretive guidance and survey process based on the revisions. The requirements under Phase 1 implemented in November 2016, included those that did not impose additional requirements on facilities or were straightforward to implement. Phase 2 requirements are new requirements and those provisions that required more complex revisions; these were implemented in November 2017. CMS also implemented a revised survey process at this time to strengthen the survey system incorporating these new requirements. On November 24, 2017, CMS announced a temporary moratorium on the imposition of certain enforcement remedies such as civil monetary penalties for eight Phase 2 requirements, because of concerns from stakeholders about the scope and timing of their implementation.⁴ CMS is using this 18-month moratorium period to educate nursing homes and providers to ensure they understand the health and safety expectations that will be evaluated through the survey process. However, the Phase 2 temporary moratorium is limited to 8 of 194 requirements and does not include those deficiencies related to abuse or neglect of residents. It also does not pause those enforcement activities that are required by federal law such as termination for immediate jeopardy findings that are not resolved. Compliance with all Phase 2 requirements is still monitored and cited, which is reflected in facilities' survey reports. In addition, all deficiencies are required by federal law to be corrected within 6 months or the facility will be terminated from participating in the Medicare and Medicaid programs.

Nursing homes are required by law to receive a recertification survey on an annual basis. Generally, state survey agencies conduct nursing home recertification surveys every year on

⁴ <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-18-04.pdf>

behalf of CMS to assess facility compliance. However, complaint surveys can be performed at any time, with the actual timing dependent on the severity of the allegation. The Nursing Home Compare website includes links and other helpful information to help patients and families determine when and how to file a complaint.⁵ In addition, nursing homes are required to post similar information on how to file complaints and grievances in their facilities.

When state inspectors identify violations of federal certification requirements, they notify the facility and in serious cases refer the case to CMS for enforcement. In most cases, the facility is required to develop a plan of correction to address identified violations within a time period depending on the scope and severity of the noncompliance violation. Enforcement actions where administrative remedies are imposed are taken against nursing homes that are not in compliance with Federal requirements. The law provides that CMS or the state authority impose one or more remedies when a facility is found to be out of substantial compliance with Federal requirements. When immediate jeopardy to resident health and safety exists (meaning that the facility's noncompliance with one or more requirements has caused, or is likely to cause, serious injury, harm, impairment, or death), a CMS Regional Office or state Medicaid agency must take immediate action to remove the jeopardy and correct the deficiency by either terminating the facility or installing temporary management in as few as two calendar days after the facility receives notice that immediate jeopardy exists. Civil monetary penalties can also be assessed up to approximately \$20,000 per day (or per instance) until substantial compliance is achieved for the deficiency identified. For deficiencies that do not constitute immediate jeopardy, remedies could include directed in-service training, denial of payments, or civil monetary penalties. Termination of a facility's Medicare and Medicaid participation is required by law for nursing homes that do not achieve substantial compliance for non-immediate jeopardy deficiencies within six months.

For those nursing homes which have more deficiencies than average, more serious deficiencies, or a pattern of serious deficiencies persisting over a long period of time, CMS may designate the

⁵ <https://www.medicare.gov/NursingHomeCompare/Resources/State-Websites.html>

nursing home as a Special Focus Facility ⁶, which requires the nursing home to be visited in person by survey teams twice as frequently as other nursing homes. CMS has strengthened the Special Focus Facility, or SFF, program over the past several years to ensure that homes either improve so that they can graduate from the program or they are terminated from Medicare/Medicaid participation. The longer the problems persist, the more stringent we are in the enforcement actions that will be taken. The objective of all remedies is to incentivize swift and sustained compliance in order to protect resident health and safety. Within about 18-24 months after a facility is identified by CMS as an SFF nursing home, we expect that the facility would improve and graduate from this program, be terminated from the Medicare or Medicaid program, or show progress but continue as an SFF nursing home for some additional time.

CMS is dedicated to maintaining an enforcement system that is centered on promoting high quality resident-centered health and safety for nursing home residents. It is always our goal to ensure patient access to care while making sure patients are safe and appropriately cared for. CMS collaborates with state partners to educate nursing homes regarding our requirements, making sure they have the information they need to address any violations found during a survey. It is our hope that our efforts will help facilities come back into compliance, as well as prevent future noncompliance, without requiring termination from the Medicare and Medicaid programs. Nevertheless, we will terminate facilities that do not appropriately correct deficiencies because it is our obligation to ensure all nursing home facilities are safe and can meet resident needs.

CMS also leads the National Nursing Home Quality Care Collaborative with the Quality Innovation Network-Quality Improvement Organizations. The Collaborative launched in April 2015 with the mission to improve care for the 1.4 million nursing home residents across the country. The Collaborative works to rapidly spread the practices of high performing nursing homes to every nursing home in the country with the aim of ensuring that every nursing home resident receives the highest quality of care. Specifically, the Collaborative strives to instill quality and performance improvement practices, eliminate healthcare-acquired conditions, and

⁶ For more information see: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/downloads/SFFList.pdf>

dramatically improve resident satisfaction by focusing on the systems that impact quality, such as staffing, operations, communication, leadership, compliance, clinical models, quality of life indicators, and specific, clinical outcomes. Every state in the country has a significant percentage of nursing homes that voluntarily participate in this collaborative.

CMS also works with GAO and HHS-OIG to identify problems and implement recommendations that can improve our oversight of nursing home facilities. For example, GAO recommended that CMS develop timeframes and milestones for the development and implementation of a standardized survey methodology across all states.⁷ CMS has implemented a new computer-based standardized survey process for nursing homes that is resident-centered which emphasizes evidence of potential quality of care issues and concerns identified through resident observation and interviews. This new survey process provides additional standardization and structure to help ensure consistency between surveyors while allowing surveyors the autonomy to make decisions based on their expertise and judgment.

Addressing Suspected Abuse and Neglect in Nursing Homes

Abuse and mistreatment of nursing home residents is never permitted, and CMS takes any allegation of these types of incidents very seriously. CMS requires nursing homes to report allegations of abuse and neglect immediately to their State Survey Agencies. When we learn a nursing home failed to report or investigate incidents of abuse, CMS takes immediate action against the nursing home. For example, in 2017, when a state surveyor found that a nursing home did not properly investigate or prevent additional abuse involving 8 residents, the nursing home was cited with noncompliance at the most serious immediate jeopardy level and was assessed a civil monetary penalty totaling approximately \$347,000. In addition to issuing civil monetary penalties, CMS can deny payments or terminate a facility's Medicare and Medicaid participation agreements when appropriate. Since November 2017, CMS has issued noncompliance deficiency citations for nursing homes for failure to report or investigate allegations of abuse or neglect 2,323 times.

⁷ See: <https://www.gao.gov/assets/680/673480.pdf>

Section 1150B of the Social Security Act requires covered individuals such as employees, contractors and operators of federally funded nursing homes to report immediately to the HHS Secretary and local law enforcement any reasonable suspicion of a crime (as defined by local law enforcement) committed against a resident of a nursing home. CMS has taken a number of steps to implement the reporting requirements under section 1150B of the Social Security Act since enactment of this provision. CMS has issued memoranda, developed education tools for nursing facility staff, and provided outreach to State Survey Agencies regarding these requirements. Specifically, in 2011, CMS issued memoranda⁸ informing nursing homes of these new reporting requirements and the process for dealing with reporting of suspected crimes. In 2012, we developed a toolkit⁹ that addressed abuse and the section 1150B reporting requirements and mailed this training program to all nursing facilities in the country. In 2016, section 1150B requirements were formally incorporated into federal regulations through notice and comment rulemaking. In 2017, CMS published sub-regulatory guidance that provided further clarification these requirements.¹⁰ Specifically, this guidance clarifies terms in the regulation such as "reasonable suspicion of a crime" and describes the process the State Survey Agency uses to evaluate compliance with the requirements. CMS also released training information related to the reporting requirements, including a video that trains surveyors and the public on the minimum facility requirements in preventing abuse and neglect of nursing home residents. The state surveyors began surveying nursing facilities specifically regarding the 1150B requirements on November 28, 2017.

Additionally, CMS has been coordinating with HHS-OIG regarding the formal delegation of the authority to impose a civil monetary penalty against individuals covered under section 1150B and the facility for retaliation against such individuals, and the authority to permissively exclude those same individuals, as well as the noncompliant facilities, from any federal health care programs. The OIG currently has similar enforcement authorities under sections 1128 and 1128A of the Social Security Act.

⁸ https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/SCLetter11_30.pdf

⁹ <https://surveyortraining.cms.hhs.gov/pubs/ClassInformation.aspx?cid=0CMSHANDINHAND>

¹⁰ <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html>

We anticipate that this formal delegation will be completed shortly. However, irrespective of the formal delegation, because a nursing home's obligations under section 1150B have been incorporated into program participation requirements, if an instance of noncompliance with these requirements by facilities were to be identified, enforcement sanctions such as civil monetary penalties, denial of payments, and termination of a facility's Medicare and Medicaid participation agreements, can be imposed under CMS's existing enforcement authority under sections 1819(h) and 1919(h) of the Act. CMS will continue to work with the HHS-OIG to enhance our ability to hold covered individuals accountable for reporting in addition to facilities as a whole and intend to issue regulations regarding enforcement following the formal delegation.

While CMS is not a law enforcement agency, we take cases of patient neglect and abuse very seriously and we work with state agencies, law enforcement, nursing home leadership and staff to ensure this vulnerable population is properly cared for and that all viable or alleged instances involving abuse or neglect are fully investigated and resolved. We are always looking to improve our programs and find better ways to identify, track, and, most importantly, prevent cases of neglect or abuse. To improve our current enforcement efforts, we will continue to work in partnership with GAO, HHS OIG, Congress, Regional Offices, states, consumer advocates, national associations, and other stakeholders.

National Partnership to Improve Dementia Care in Nursing Homes

Through our the National Partnership to Improve Dementia Care in Nursing Homes¹¹ (National Partnership), CMS has partnered with federal and state agencies, nursing homes, other providers, advocacy groups, and caregivers to improve comprehensive dementia care. CMS and our partners are committed to finding new ways to implement practices that enhance the quality of life for people with dementia, protect them from substandard care and promote goal-directed, person-centered care for every nursing home resident. The Partnership promotes a multidimensional approach that includes public reporting, state-based coalitions, research, training, and revised surveyor guidance. While the initial focus of the partnership was on

¹¹ <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/National-Partnership-to-Improve-Dementia-Care-in-Nursing-Homes.html>

reducing the use of antipsychotic medications, the larger mission is to enhance the use of nonpharmacologic approaches and person-centered dementia care practices.

Since the launch of the National Partnership, significant reductions in the prevalence of antipsychotic medication use in long-stay nursing home residents have been documented. Between the end of 2011 and the end of quarter one of 2017, the national prevalence of antipsychotic use in long-stay nursing home residents was reduced by 34.1 percent, decreasing from 23.9 percent to 15.7 percent nationwide. All 50 states showed improvement with some states showing much more improvement than others. The National Partnership continues to work with state coalitions and nursing homes to reduce that rate even further. In October 2017, CMS announced a new national goal, involving a 15 percent reduction of antipsychotic medication use by the end of 2019¹² for long-stay residents in those homes with currently limited reduction rates. Our progress to date indicates that we are about half-way towards meeting that 15 percent goal. This goal builds on the progress made to date and expresses the Partnership's commitment to continue this important effort. We are continuing to look for opportunities to strengthen both the survey process and enforcement efforts to ensure that nursing homes are focused on non-pharmacologic approaches and residents are not receiving medications that do not have a clinical basis.

Ensuring Quality of Care by Putting Patients Over Paperwork

In addition to our monitoring and oversight of facilities, our Agency-wide efforts to return patients to the center of care by incentivizing improved quality and reducing provider burden play a critical, complementary role to our commitment to safeguarding the health of nursing home residents. Through our Patients Over Paperwork initiative¹³, CMS is reducing provider burden and allowing clinicians to spend more time with their patients – this is particularly important in a nursing home setting where residents have more complex care needs, and care decisions are often directed by family members. Reducing provider burden can also lower

¹² <https://www.cms.gov/newsroom/fact-sheets/data-show-national-partnership-improve-dementia-care-achieves-goals-reduce-unnecessary-antipsychotic>

¹³ <https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/PatientsOverPaperwork.html>

administrative costs, allowing facilities to dedicate their resources to other areas such as patient care.

CMS has been working tirelessly to evaluate and streamline regulations and operations with the goal to reduce unnecessary burden, increase efficiencies, and improve the customer experience. We have used several tactics to help us better understand burden related to nursing homes, from formal requests for information from stakeholders to engaging stakeholders directly to provide feedback to CMS on areas of burden. In a May 2017 proposed rule,¹⁴ we stated that we are currently reviewing the nursing home requirements to balance the need to maintain quality of care while reducing procedural burdens on facilities. Specifically we noted that we are reviewing the requirements for obsolete or redundant provisions, areas where processes can be streamlined to reduce burden and cost, or other areas of possible elimination. We asked stakeholders for feedback in areas of burden placed by the revisions to the nursing home requirements and the potential impact of resident care and outcomes. We are considering potential changes to the requirements based on the feedback received.

In the Fiscal Year 2019 Skilled Nursing Facility Prospective Payment System Final Rule, CMS is moving towards a new patient-driven case-mix model system in Medicare to pay for services to residents in skilled nursing facilities. The new Patient-Driven Payment Model is designed to improve the incentives to treat the needs of the whole patient, instead of focusing on the volume of services the patient receives, which requires substantial paperwork to track over time. The Patient-Driven Payment Model simplifies complicated paperwork requirements for performing patient assessments by significantly reducing reporting burden (approximately \$2.0 billion over 10 years), helping to create greater contact between health care professionals and their patients. This improved case-mix classification system moves Medicare towards a more value-based, unified post-acute care payment system that puts unique care needs of patients first while also significantly reducing administrative burden.

<https://www.gpo.gov/fdsys/pkg/FR-2017-05-04/pdf/2017-08521.pdf>

On September 7, 2017, CMS released a facility assessment tool¹⁵ that helps a nursing home determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. The intent of the facility assessment is for the facility to evaluate its resident population and identify the resources needed to provide the necessary person-centered care and services the residents require. The tool may also be used by facilities to make decisions about direct care staff needs as well as capabilities to provide services to residents.

Promoting Transparency, Rewarding Quality, and Encouraging Competition

Skilled Nursing Facility Quality Reporting Program and Value-Based Purchasing Program

In recent years, we have undertaken a number of initiatives to promote higher quality and more efficient health care for Medicare beneficiaries. These initiatives include Skilled Nursing Facility Quality Reporting Program and Skilled Nursing Facility Value-Based Purchasing (VBP) Program. The overarching goal of these initiatives is to transform Medicare from a passive payer of claims to an active purchaser of quality health care for its beneficiaries.

The Skilled Nursing Facility Quality Reporting Program is authorized by the Social Security Act and applies to skilled nursing facilities and most swing-bed rural hospitals. The goal of the program is to use standardized quality measures and standardized data to enable interoperability and access to longitudinal information for providers to facilitate coordinated care, improved outcomes, and overall quality comparisons. Measures that are reported under the program include functional status, cognitive status, skin integrity, medication reconciliation, and major falls. In addition, measures on readmissions, discharge to community and Medicare spending per beneficiary are calculated using claims data, so skilled nursing facilities do not have to submit additional data for these measures. Under the program, skilled nursing facilities that fail to submit the required quality data to CMS are subject to a 2 percentage point reduction to the otherwise applicable annual market basket percentage update with respect to that fiscal year.

The implementation of the SNF VBP Program is an important step toward transforming how care is paid for, moving increasingly toward rewarding better value, outcomes, and innovations

¹⁵ <https://qioprogram.org/facility-assessment-tool>

instead of merely volume. As required by law¹⁶, beginning October 1, 2018, the SNF VBP Program will make positive or negative adjustments to the otherwise applicable payments under the Skilled Nursing Facility Prospective Payment System for services furnished by SNFs based on their performance on the program's readmissions measure. The single claims-based all cause 30-day hospital readmissions measure in the SNF VBP aims to improve individual outcomes through rewarding providers that take steps to limit the readmission of their patients to a hospital. Also as required by law, CMS will make available SNFs' performance under the SNF VBP Program, specifically including each SNF's performance score and the ranking of SNFs for each fiscal year.

Nursing Home Compare Five-Star Quality Rating System

Transparency is an important part of CMS's patient safety work and CMS is committed to making sure that patients and their families have the information they need to support their health care decisions for LTC facilities. CMS first created the Nursing Home Compare website in 1998 and has regularly increased the amount of information available to beneficiaries and their families about the quality of care in nursing homes participating in the Medicare and Medicaid programs.

CMS bases the five-star ratings of the Nursing Home Five Star Quality Rating System on an algorithm that calculates a composite view of nursing homes from three measures: results from their health inspections; performance on certain quality measures; and their staffing levels. CMS's Nursing Home Compare Website contains information for more than 15,000 Medicare and Medicaid nursing homes around the country. The website also includes detailed reports on facility health inspections, life safety code inspections and any identified noncompliance deficiency citations.

CMS has continually made improvements to Nursing Home Compare and the Five Star Quality Rating System to enhance and strengthen the comparison tool to provide the most accurate information to beneficiaries and their families. Throughout the years, CMS has added information to Nursing Home Compare, including information on facility ownership, federal administrative sanctions against nursing homes, and the full text of the nursing home health

¹⁶ Section 1888(h) of the Social Security Act.

inspection reports. CMS implemented Nursing Home Compare 3.0 to strengthen and expand the Five Star Quality Rating System by adding quality measures, raising nursing home performance expectations, adjusting the methods for establishing staffing ratings, and expanding targeted surveys. In 2016, CMS expanded the number of quality measures included in Nursing Home Compare and the Five Star Quality Rating System. In April 2018, we replaced the data source for staffing information submitted by facilities through the Payroll-Based Journal system which improves the accuracy of the staffing information on Nursing Home Compare. CMS continues to work to improve Nursing Home Compare and the Five Star Quality Rating System. For example, in October 2018, we will be adding a measure of hospitalizations among long-stay residents as part of our continued efforts to improve quality and reduce costs.

Tracking Nursing Home Staffing Data

CMS has long identified staffing as one of the vital components of a nursing home's ability to provide quality care. Current law requires facilities to electronically submit direct care staffing information (including agency and contract staff) based on payroll and other auditable data. In 2015, CMS developed the Payroll-Based Journal system, which allows all facilities to submit their staffing data each quarter. The data, when combined with census information, is then used to calculate the level of staff in each nursing home. Last April, CMS began using the Payroll-Based Journal data to post staffing information on the Nursing Home Compare tool. This new staffing information is calculated using the number of hours facility staff are paid to work each day in a quarter, instead of the previous method of calculating staffing information using the total number of hours facility staff work over a two-week period. Also, unlike the previous data source, the new data are auditable back to payroll and other verifiable sources. These data provide unprecedented insight into how facilities are actually staffed, which can be used to analyze how facilities' staffing relates to quality and outcomes. In the future, we will also use this data to report on employee turnover and tenure, which also impacts the quality of care delivered.

While the new data warrants additional scrutiny and actions to ensure its accuracy and usefulness to consumers, we believe it will ultimately lead to improved staffing and result in better quality and care for nursing home residents. Already, the new data has helped us identify issues, such as

significant variations in staffing between weekdays and weekends, and days with no registered nurse reported onsite. We are deeply concerned about these issues and are working with nursing homes to address them. For example, facilities who report seven or more days with no registered nurse hours are now assigned a one-star staffing quality rating. We are also planning to use the Payroll-Based Journal data to inform surveyors' investigations to help determine if staffing is an underlying cause of any quality issues. Furthermore, since the start of the program, we have been providing individualized feedback to each facility about their staffing data for them to use to improve the accuracy of future submissions. We will continue to accumulate and analyze the data to ensure that nursing homes are staffing their facilities appropriately in order to provide quality care to residents.

Moving Forward

Resident safety is our top priority in nursing homes that participate in the Medicare and Medicaid programs. We expect every nursing home to keep its residents safe and provide high quality care. CMS remains diligent in its duties to monitor nursing homes participating in Medicare and Medicaid across the country, and we look forward to continuing to work with Congress, states, facilities, residents and other stakeholders to make sure the residents we serve are receiving safe and high quality health care.

Mr. HARPER. Thank you, Dr. Goodrich.

The chair will now recognize Ms. Dorrill for 5 minutes for the purposes of your opening statement.

STATEMENT OF RUTH ANN DORRILL

Ms. DORRILL. Good morning, Chairman Harper, Ranking Member DeGette, and other distinguished members of the subcommittee.

I have been visiting nursing homes on behalf of the OIG for 20 years. When you speak with the people who have chosen to spend their professional lives in these settings, they will tell you that nursing home care is incremental. By that I mean that the gains and the losses can be small and around the margins.

Nursing homes can be places of comfort and healing. They can make the difference between someone having 10 more good years or a downward spiral. But it's important to recognize that people who enter nursing homes are at low points at times of crisis. They often have not only an acute condition that landed them there in the first place, but they have many competing comorbidities and complex conditions on top of that.

Many of the facilities as you've said provide excellent care, but an alarming number of residents are subject to unsafe conditions, much of which is preventable with better guidance and government oversight. Our work has found widespread, serious problems in nursing home care and my remarks today will rest on three priority areas: harm to nursing home residents, emergency preparedness of nursing homes, and the important role of the state agencies.

First, in regard to harm, OIG has expended extensive time and focus on the problem of resident harm as it's been referenced already today, including harm from medical care known as adverse events. In a national study of hundreds of nursing homes, we found that a third of residents, 33 percent, one in three, were harmed by medical care—infections, blood clots, aspiration—and half of this harm, 59 percent, was preventable.

And an important point, one of the interesting things about this study to us was that most of these events weren't big, dramatic events that you think about when you think about harm or adverse events. Most of them were incremental. They were small. They were surrounding the daily, hourly care that's provided by certified nurse assistants and staffing throughout the nursing home.

And there are things that the staff didn't recognize and, in many cases, the family didn't recognize. The same is happening in hospitals. This low level, substandard care harms a tremendous number of people and we've recommended that CMS develop guidance and revise requirements for detecting and preventing this harm, the detection being a key component.

Residents also of course face abuse and neglect. In 2012, we found that only half of nursing homes were reporting allegations of abuse and neglect. And then we went back just last year in 2017 and looked at emergency room records and we found that it was still a substantial problem. There were many cases that were not reported by the nursing homes. We urged CMS at that time to take immediate action to monitor claims and to enforce against those

who fail to report. OIG also works in the law enforcement side with our partners to hold accountable those who victimize residents.

Next, on emergency preparedness. So after Hurricane Katrina and other storms in 2005 we went into, we had found in looking at the deficiencies that almost all nursing homes met their emergency provisions. Ninety four percent were in compliance and yet when we visited a sample of homes who were actually affected by the hurricanes, we found that the plans weren't practical and up-to-date. That in many cases the nurses would pull out a pad and pen when they saw the hurricane coming as opposed to looking at the binder on the shelf.

We also found that once the storms hit and in their aftermath that whether the nursing homes evacuated or sheltered in place that they had problems with transportation, with staffing, with supplies, anything that you can imagine. We also found this for wildfires and for flooding.

When we went back, we also were struck by the fact that after additional storms—Ike, Gustav in 2009–2010—we found essentially the same thing, no improvement besides additional guidance by CMS. We recommended that CMS develop targeted guidance in requirements and as Dr. Goodrich said state agencies began assessing homes for these requirements last November.

Finally, I want to further emphasize the critical role of the state agencies in citing deficiencies when homes aren't up to snuff. In recent work, we found that seven of nine states did not consistently verify that homes actually corrected the deficiencies that the states had cited. In another study, we found that States weren't enforcing very critical core components, care and discharge planning, which are very important to patient outcomes. We recommended the States strengthen those procedures. And the report was in 2013, the recommendations were implemented just a few months ago in June of 2018.

In closing, the through line here is that while CMS has taken steps to create a framework for improvement, all progress will lie in the execution on the part of CMS, on the part of the state agencies, and on the part of the nursing homes. This means focused education and accountability from CMS and also staying alert to the impact of changes. Are the requirements understood, the new requirements by inspectors and homes are they practical? Do they improve care? None of that can really be assumed and the consequences are great.

OIG is recommending that CMS do more to protect nursing home residents and we are committed to that as well. We have ongoing work assessing a number of areas and we thank you for your ongoing leadership in this area and for the opportunity today.

[The prepared statement of Ms. Dorrill follows:]



Testimony Before the United States House of Representatives
Committee on Energy and Commerce
Subcommittee on Oversight and Investigations

**"Examining Federal Efforts to Ensure Quality of Care
and Resident Safety in Nursing Homes"**

Testimony of:

Ruth Ann Dorrill
Regional Inspector General
Office of Inspector General
U.S. Department of Health and Human Services

September 6, 2018

10:15 a.m.

Location: 2322 Rayburn House Office Building

**Testimony of:
Ruth Ann Dorrill
Regional Inspector General**

Office of Inspector General, U.S. Department of Health and Human Services

Good morning, Chairman Harper, Ranking Member DeGette, and other distinguished Members of the Subcommittee on Oversight and Investigations. Thank you for the opportunity to appear before you to discuss one of the most consequential issues in health care today: ensuring safe, quality care for residents in the Nation's nursing homes.

KEY TAKEAWAYS

High-quality nursing homes can deliver enormous benefit as places of comfort and healing. For Medicare beneficiaries, nursing homes provide a clinically managed recovery period after illness and injury that can make the difference between more good years ahead or a downward spiral. For long-term-care residents and their families, often insured through Medicaid, nursing homes can provide responsible and much-needed care to those in fragile health.

Many nursing homes provide excellent care and are diligent in protecting their residents. But an alarming number of residents are subject to costly medical harm, unsafe conditions, and abuse and neglect, much of it preventable with better practices and oversight.

Nursing home care is a critical component of the continuum of care. Quality and safety of care in nursing homes affect the provision and cost of care in other settings. With an aging population and heightened focus on value-driven care, it is increasingly critical that Federal and State funds are used to purchase safe, high-quality care for vulnerable elderly and disabled patients.

Decades of OIG work on nursing homes has uncovered widespread problems in providing safe, high-quality care and reporting problems when they occur. We found that one in

three Medicare residents in skilled nursing facilities experienced harm from the care provided, and half of these harm events were preventable. In addition, nursing homes affected by disasters, such as hurricanes, often struggle to execute emergency plans and protect residents. We have also raised concerns about failures to report potential cases of abuse and neglect. Criminal and civil enforcement actions have uncovered misconduct and grossly substandard care. State Agencies play a crucial role in ensuring quality and safety in nursing homes. However, OIG has found mixed results in these agencies' attention to nursing home deficiency corrections and complaints.

Addressing the challenge of improving nursing home safety and quality of care requires strong leadership by CMS and serious, sustained commitment and effort by CMS, States, and the provider community.

My testimony today will focus on significant OIG findings and recommendations regarding nursing home quality and safety in three key areas:

- Harm to residents in nursing homes
- Nursing home emergency preparedness
- State Agency enforcement

OVERVIEW OF ACCOUNTABILITY FOR NURSING HOME CARE AND OVERSIGHT

According to CMS, Federal expenditures on nursing home care totaled \$73 billion in 2016, including \$44 billion for Medicaid long-term care and \$29 billion for Medicare post-acute and other skilled care. Most nursing homes are certified to serve as both long-term-care facilities and skilled nursing facilities (SNFs). Long-term-care facilities provide health-related care and services needed as a result of a mental or physical condition and may serve beneficiaries whose condition may not rise to the level of needing skilled nursing care. SNFs provide skilled nursing

care and rehabilitation services for residents who require such care because of injury, disability, or illness, typically following a hospital stay. Meeting the needs of these two different populations, long-term care and skilled post-acute care, can complicate the effective management of facilities, and make oversight more challenging.

CMS and States share responsibility for ensuring that nursing homes meet Federal requirements for quality and safety. State Agencies are required by CMS to conduct a “survey” (inspection) of nursing homes at least every 15 months to certify each facility’s compliance. CMS oversees the State certification process and provides guidance regarding the survey process in its State Operations Manual (SOM) and Interpretive Guidelines.

When State Agencies identify deficiencies during their surveys, nursing homes must submit correction plans, and State Agencies must verify that the facility corrected its deficiencies. CMS and State Medicaid agencies may also take enforcement actions to address nursing home deficiencies, including imposing civil monetary penalties or terminating the nursing home from the Medicare Program, among other actions, as appropriate.

OIG WORK ADDRESSING HARM TO RESIDENTS IN NURSING HOMES

OIG found that that one in three SNF residents experienced adverse events during their nursing home stays, including infections, pressure ulcers, and misuse of medication.

In a nation-wide review, OIG found that one-third of residents in SNFs experienced harm from the care provided in the nursing homes and more than half of the harm (adverse events) were preventable had the facilities provided better care. This report was one in a decade-long OIG series regarding adverse events in various healthcare settings, including hospitals.

The adverse events OIG identified in nursing homes resulted in a range of harmful outcomes for residents, including extended stays in the SNF, transfers to hospital emergency departments, and the need for life-sustaining intervention. For 6 percent of the adverse events,

the harm contributed to residents' death. Over half of the residents who experienced harm returned to a hospital for treatment, incurring millions of dollars in additional Medicare expenditures.¹

Some adverse events involved medical errors such as supplying incorrect medication, but most preventable harm resulted from daily substandard care, such as inadequate resident monitoring and failure or delay of necessary care. For these adverse events, residents and families may not know that they were harmed, thinking instead that the residents' suffering and decline were the result of their illness or conditions and inevitable. Nursing home staff also failed to identify harm in some cases; for example, a number of adverse events started with dehydration, which can quickly result in kidney damage. One nursing home resident died of cardiac arrest after progressive kidney failure that was not detected until the resident was awaiting discharge from the SNF.

Most nursing home residents who died or were harmed from adverse events had multiple, complex co-morbidities that made their care challenging. We found a wide range of adverse events not typically associated with nursing home care, such as internal bleeding due to medication. While some events are widely recognized as risks for patients in nursing homes, such as falls and pressure ulcers, fewer nursing home staff may be aware of the risks posed by aspiration and blood clots, both of which harmed numerous patients in our study sample. In our review of CMS and other guidance, we noted a tendency to focus narrowly on a subset of the most extreme harm events, many of which are rare, while missing the broad range of possible, more common harms that cause patient declines.

¹ OIG, *Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries* (OEI-06-11-00370), issued February 2014. For this evaluation, OIG contracted with physicians who were experts in SNF care, surgery, cardiology, and infectious disease to conduct an extensive medical review of SNF stays.

What is needed is a shift in thinking about the care provided in nursing homes. Our work identifying adverse events in nursing homes and other settings showed that nursing home residents often had care needs similar to patients in hospitals, with residents sometimes seriously ill and impaired. The hospital community has focused keenly on patient safety and, while still experiencing high harm rates in some categories, has made substantial changes in the provision of patient care and safety systems. Sustained improvements in nursing homes will require a cultural shift that recognizes clinical harm and elevates reduction of harm as a priority for nursing home care.

The foundation of OIG's recommendations to reduce harm is that CMS (and the Agency for Healthcare Research and Quality) raise awareness of adverse events in nursing homes (and other post-acute-care settings) with the same methods used to promote hospital safety. Broadening these and other patient safety improvement efforts to include the nursing home environment would ensure that safe care practices promoted in acute care hospitals extend to the critical periods of post-acute recovery and long-term care.

To address the high rate of harm in nursing homes, OIG made two recommendations to CMS: (1) provide guidance to nursing homes about detecting and reducing harm to be included in facility Quality Assurance and Performance Improvement programs, and (2) instruct State Agencies to review facility practices for identifying and reducing adverse events, and link related deficiencies specifically to resident safety practices. OIG determined that CMS fully implemented these recommendations on adverse events in SNFs as of August 2018. It is too early to assess the effectiveness of CMS's actions in changing practices, but they hold promise for improving quality of care and reducing adverse events for nursing home residents.

Meaningful improvement will rest on diligent execution by CMS and States, and continued evaluation of the effectiveness of these changes.

OIG has raised concerns about failure to report allegations or potential cases of abuse and neglect of nursing home residents.

It is both required and expected that nursing homes will report allegations of abuse or neglect to law enforcement or other appropriate agencies to ensure resident safety and protect victims of crimes. However, OIG has documented serious deficiencies in reporting of abuse and neglect of nursing home patients dating back several years and continuing in our recent and ongoing work. OIG found that, in 2012, nearly one in four nursing facilities did not have policies for reporting allegations of abuse or neglect and the subsequent results of an investigation, and facilities reported only half of allegations and investigation results as federally required.² In response to OIG recommendations that CMS ensure nursing homes maintain policies for reporting allegations of abuse or neglect and report allegations in a timely manner, CMS revised the SOM in 2017 to instruct State Agency surveyors to assess facility policies and practices.

Yet concerns about unreported abuse and neglect remain. OIG reviewed hospital emergency room records from 2015 and 2016 for SNF residents sent to hospitals whose injuries may have been the result of potential abuse or neglect in the SNF. In preliminary work, OIG found 134 such incidents across 33 States. We further found that many of these incidents may not have been reported to law enforcement. Pending completion of the full review, OIG alerted CMS that it had inadequate procedures to ensure that incidents of potential abuse and neglect at

² OIG, *Nursing Facilities' Compliance with Federal Regulations for Reporting Allegations of Abuse or Neglect* (OEI-07-13-00010), issued in August 2014.

SNFs are properly identified and reported.³ OIG made immediate suggestions for improvement, including that CMS analyze Medicare claims (including matching claims for emergency room services to claims for SNF services) to identify incidents of potential abuse and neglect and take specific steps to enhance its ability to impose civil monetary penalties for reporting failures.

OIG investigations and enforcement cases illustrate that nursing home harm can involve conduct by individual bad actors, as well facility and chain-wide conduct

OIG investigates potential criminal conduct and pursues enforcement actions to hold accountable those who victimize residents of nursing homes. In some cases, this involves criminal activity by bad actors. For example, in 2018, the owner of a long-term-care facility was convicted of engaging in the physical and emotional abuse of one of its residents, following an investigation by OIG and our law enforcement partners.

In other cases, facility-wide or chain-wide grossly substandard care can harm patients. Such cases may result in civil False Claims Act resolutions or administrative actions, such as exclusion. Patient neglect, often due to understaffing, is a recurring issue in False Claims Act cases. Other allegations that commonly arise in these cases include overmedication of nursing home residents, which may lead to falls and fractures; failure to follow physicians' orders; and failure to provide a habitable living environment, with concerns including mold and roof leaks.

NURSING HOME EMERGENCY PREPAREDNESS

Despite enhanced guidance from CMS, nursing homes hit by disaster often struggle to execute emergency plans and protect residents.

Nursing home residents and their families rely on facility administrators to plan and execute appropriate procedures during disasters. Through years of visiting nursing homes after

³ OIG, *Early Alert: The Centers for Medicare & Medicaid Services Has Inadequate Procedures to Ensure That Incidents of Potential Abuse or Neglect at SNFs Are Identified and Reported in Accordance With Applicable Requirements* (A-01-17-00504), issued in August 2017.

disasters, we have learned that facilities may ostensibly meet CMS guidelines prior to the disaster, but at the time of crisis fail to follow requirements and prior planning.

In 2006, following Hurricanes Katrina, Rita, and others, OIG found that 94 percent of the Nation's nursing homes met Federal regulations for emergency plans. In visiting 20 nursing homes affected by hurricanes, however, we found that these plans were often not practical or up to date, and that during the crisis many administrators did not know how to navigate CMS guidelines and instructions from local authorities, and they often did not have adequate supplies, staffing, or transportation in place to care for residents. These findings indicated that State Agency reviews of emergency plans were insufficient, and that the plans themselves were often not useful.⁴ In a followup study by OIG in 2012, after CMS had revised its guidance to include a suggested checklist for preparedness, we visited nursing homes affected by a range of disasters and found that only half had plans that included the checklist items.⁵

For nursing homes that continued to operate without adequate emergency planning, the omissions were often a matter of common sense and the consequences for residents extreme. One nursing home that flooded during a storm had no plan for responding to floods, despite residing in a flood plain. Other homes evacuated residents to facilities far away and without sufficient tracking or methods to ensure residents traveled with personal equipment and supplies, such as wheelchairs and medication. Administrators from most nursing homes that OIG studied reported that residents experienced deteriorating health conditions, skin issues, and falls resulting in serious injury. This occurred in nursing homes that evacuated and those that sheltered in place. In some cases of evacuation, residents' poor conditions necessitated hospitalization.

⁴ OIG, *Nursing Home Emergency Preparedness and Response during Recent Hurricanes* (OEI-06-06-00020), issued August 2006.

⁵ OIG, *Gaps Continue To Exist in Nursing Home Preparedness and Response After Disasters* (OEI-06-09-00270), issued April 2012.

Reports of nursing homes' performance in the aftermath of the 2017 hurricanes—including failures to evacuate residents or to provide safe sheltering in place—raise continued questions about the adequacy of emergency plans and their proper execution.

OIG recommended that CMS require facilities to create effective emergency plans and take other specific actions in preparing for emergencies, such as improving staff training and communication with local authorities. In 2016, CMS revised its emergency preparedness requirements for nursing homes and other healthcare facilities that participate in Medicare and Medicaid, to include specific provisions for planning, training, and communication. State Agencies began assessing compliance for these provisions in November 2017. OIG will continue to monitor these important provisions.

STATE AGENCY ENFORCEMENT

State Agencies play a critical role in ensuring the quality and safety of nursing homes, and OIG has found mixed results in State Agency attention to nursing home deficiencies.

From 2015 to 2018, OIG completed audits of nine States to determine whether the State Agency took appropriate steps to verify that nursing facilities had corrected identified deficiencies. OIG found that State Agencies in seven of nine States were not meeting requirements to verify correction of deficiencies.⁶ Lack of verification was evident in both serious and minor deficiencies. For example, surveyors found that a nursing home failed to provide a resident oxygen per physician orders; the corrective action plan included additional training for nursing staff. Yet the State Agency was unable to confirm that the staff involved attended the training.

⁶ OIG's State audits included Arizona (A-09-16-02013), Florida (A-04-17-08052), Kansas (A-07-1703218), Missouri (A-07-16-03217), Nebraska (A-07-17-03224), New York (A-02-15-01024), North Carolina (A-04-17-02500), Oregon (A-09-16-02007), and Washington (A-09-13-02039).

OIG also found that one of the nine States reviewed did not conduct standard surveys for approximately 40 percent of nursing homes within the required 15 months. For seven States that did not meet requirements, OIG recommended that State Agencies improve verification processes, update internal systems, and for the one State, develop a correction plan to ensure the State conducts timely surveys. OIG found that the remaining two States were in full compliance. Four of the States with recommendations implemented them, including the State not performing timely surveys. Recommendations for three of the States remain outstanding, including two States that received our audit reports only within the last few months.

Other OIG findings indicated that State Agency oversight of SNFs was not sufficient to ensure that SNFs developed and followed care and discharge plans for residents, as required. These care and discharge plans can be the linchpin of effective SNF care, helping to ensure that residents receive needed care, protecting residents from receiving unnecessary care, and assisting them in securing home- and community-based care and personal care services that can prevent them from re-entering the SNF or a hospital.

OIG made extensive recommendations to CMS that the agency address this problem from multiple vantage points: (1) strengthen the regulations on care and discharge planning, (2) provide guidance to SNFs to improve planning, (3) increase surveyor efforts to identify problems, (4) link payments to meeting quality-of-care requirements, and (5) follow up on the SNFs that failed to meet requirements.⁷ In June 2018, OIG determined that CMS had fully implemented these recommendations. We will continue to monitor the extent to which CMS's and State Agencies' actions resolve the problems and improve care.

State Agencies serve as front-line responders to address health and safety complaints in

⁷ OIG, *Skilled Nursing Facilities Often Fail to Meet Care Planning and Discharge Requirements* (OEI-02-09-00201), issued February 2013.

nursing homes. State Agencies are responsible for onsite investigations of serious complaints of abuse and neglect. OIG work in 2017 found that a few states fell short in timely investigations of the two most serious categories of complaints: immediate jeopardy and high priority.⁸

NEXT STEPS TO IMPROVE NURSING HOME QUALITY AND SAFETY

Sustained commitment by CMS and continued collaboration among HHS, States, providers, and residents and their families will be critical to ensuring quality and safety.

Quality nursing home care requires a partnership between a large and diverse group of Federal, State, and local entities. Residents and their families are also critical stakeholders. As the Federal agency charged with oversight of nursing home compliance and performance, CMS must demonstrate strong leadership of this group. Effective collaboration will narrow gaps, provide better information and insight, and give greater assurance to residents and their families that they will receive high-quality care.

As an example, following the 2011 OIG report *Medicare Atypical Antipsychotic Drug Claims for Elderly Nursing Home Residents*, CMS led an effort across HHS to correct improper drug prescribing and use in nursing homes. OIG found that 83 percent of atypical antipsychotic drug claims were for elderly nursing home residents not diagnosed with a condition for which the Food and Drug Administration (FDA) had approved antipsychotic medications. This supported a theory long held by residents' advocates that nursing homes used atypical antipsychotic medications for "off-label" indications, with the purpose of controlling undesirable behavior. Both CMS and FDA took action to make changes to regulations and guidance, and CMS formed a public-private effort, the National Partnership to Improve Dementia Care in Nursing Homes, to engage providers, advocates, and families. Subsequent CMS data show

⁸ OIG, *A Few States Fell Short in Timely Investigations of the Most Serious Nursing Home Complaints: 2011-2015* (OEI-01-16-00330), issued September 2017.

substantial reductions in the use of these drugs among nursing home residents. Given the number of stakeholders involved and the urgency of the problems, this type of public-private partnership would be useful for CMS to foster improvements across nursing home care.

Further, it is critical that States remain active participants in the Federal-State partnership needed to oversee nursing homes. States are on the front line in surveying nursing homes, identifying deficiencies, and verifying corrections. States play an essential enforcement role when residents are victims of abuse and neglect. States' active participation in ensuring that nursing homes are providing safe, high-quality care is essential to improving patient outcomes and reducing adverse events.

To protect nursing home residents, OIG will continue to assess CMS oversight and nursing home and State Agency performance, monitor the impact of program changes, and use our enforcement tools to address misconduct.

Nursing home residents deserve and should expect high-quality care and to be safe from abuse and neglect. OIG will continue to monitor whether CMS's recent actions to improve safety and quality produce the intended positive outcomes. Moreover, OIG will follow up on its findings and recommendations to State Agencies to strengthen the effectiveness of their efforts.

OIG has upcoming work that will assess multiple dimensions of nursing home quality and safety to protect beneficiaries. These audits and evaluations follow up on past findings and recommendations, and examine new areas, such as nursing home compliance with new Life and Safety Code requirements, assessment of the accuracy and use of new nursing home staffing data, and the extent to which State Agencies investigate involuntary resident transfers and discharges.

Allegations involving patient harm remain a top OIG enforcement priority. OIG will continue to investigate potential criminal conduct and pursue administrative actions to hold

accountable those who victimize residents of nursing homes. In resolving False Claims Act cases, OIG may enter into “quality of care” corporate integrity agreements (CIAs) with nursing homes or chains that require actions to improve quality of care and safety. OIG is currently monitoring quality of care CIAs covering more than 200 nursing homes. OIG also collaborates closely with the 50 State Medicaid Fraud Control Units (MFCUs) that often have primary responsibility for enforcement of cases of abuse and neglect in nursing homes.

CALL TO ACTION

To provide guidance, support, and oversight of this industry is a grave and vitally important responsibility. Government policies and leadership, Federal and State, can substantially affect residents’ experience and outcomes. The problems I present today are not new, and they may seem daunting and intractable given the challenges and complexities of nursing home care. But change is possible, and essential. Nursing home care will always be a deeply challenging enterprise, but with dedicated attention and focus, CMS, States, and providers can do better.

While CMS has taken steps to create a framework for correcting problems of resident harm and risk, all progress will be in the execution of that framework and the performance of CMS, States, and providers. CMS must stay alert to the impact of policies and practices and promote meaningful, sustainable change. OIG is committed to working with CMS as it takes action to address problems identified by our work, the Government Accountability Office, and others.

Thank you for your ongoing leadership in this area and for affording OIG the opportunity to testify and discuss with you this vitally important topic.

Mr. HARPER. Thank you, Ms. Dorrill.

We will now recognize Mr. Dicken for 5 minutes for the purposes of his opening statement. Thank you.

STATEMENT OF JOHN DICKEN

Mr. DICKEN. Chairman Harper, Ranking Member DeGette, and members of the subcommittee, I'm pleased to be here today to discuss GAO's body of work on nursing home quality and the Center for Medicaid and Medicaid Services oversight of nursing homes.

For many years, GAO has reported on problems in nursing home quality and weaknesses in CMS' oversight. As early as 1998, GAO reported that despite Federal and State oversight, certain California nursing homes were not sufficiently monitored to guarantee the safety and welfare of their residents. In the intervening 2 decades across more than two dozen reports, GAO has consistently found shortcomings in the care that some nursing home residents received and in Federal and State oversight of nursing homes.

In response to identified weaknesses, CMS and state survey agencies have made a number of changes in their oversight. Inspection protocols have been updated, enforcement tools have been revised, and consumers have been provided more information to compare nursing homes. Yet, we continue to see mixed results in indicators intended to assess the quality of care. Further, we lack full assurance of these indicators including information made available to consumers are consistently based on accurate data and we remain concerned that the prevalence of serious care problems remains unacceptably high.

In my remaining time I'd like to briefly summarize key takeaways from GAO reports issued in 2015 and 2016 that examine trends in nursing home quality, information made available to consumers for comparing nursing homes, and changes CMS had made to its oversight activities. I will also note CMS' responses to recommendations we made.

First, we found that data on nursing home quality showed mixed results. We found an increase in reported consumer complaints through 2014, suggesting that consumers' concerns about nursing home quality increased. In contrast, trends in care deficiencies, nurse staffing levels, and clinical quality indicators through 2014 indicate potential improvement.

Second, we found data issues complicated the ability to assess quality trends. For example, at that time CMS allowed states to use different survey methodologies to measure deficiencies in nursing home care. GAO recommended CMS implement a standardized survey methodology across states and in November 2017 CMS completed national implementation. Further, GAO recommended CMS implement a plan for ongoing auditing of quality data that had been self-reported by nursing homes. The agency concurred and has begun auditing staffing data that now relies on payroll-based reporting, but CMS does not have a plan to audit certain other quality data on a continuing basis.

Third, in the 2016 report we found CMS did not systematically prioritize recommended changes to improve its Nursing Home Compare website. In several factors it limited consumers' ability to use CMS' five-star rating system. CMS agreed with these rec-

ommendations and earlier this year completed actions establishing a process to prioritize website improvements and adding explanatory information about the five-star system. But CMS has not yet acted on other recommendations including providing national comparison information that could help consumers better make distinctions between nursing homes.

Fourth, CMS had modified certain oversight activities at the time of our 2015 report and those steps have continued. Some modifications expanded activities such as creating new training for state surveys on unnecessary medication use, others reduced existing activities. For example, CMS reduced the scope of Federal monitoring surveys which may decrease CMS' ability to monitor whether state survey agencies understate serious care deficiencies. Similarly, CMS reduced the number of homes designated as special focus facilities which may limit its ability to monitor homes with poor performance. GAO recommended CMS monitor the effects of these modifications and CMS indicates it is beginning to take steps to do so.

In closing, addressing the long-term concerns that nursing residents receive unacceptable care requires sustained Federal and state commitment. We maintain the importance of monitoring to help CMS better understand how oversight modifications affect nursing home quality and to improve its oversight given limited resources.

Chairman Harper, Ranking Member DeGette, and members of the subcommittee, this concludes my prepared statement. I'd be pleased to answer any questions that you may have.

[The prepared statement of Mr. Dicken follows:]

United States Government Accountability Office



Testimony Before the Subcommittee on
Oversight and Investigations,
Committee on Energy and Commerce,
House of Representatives

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NURSING HOME QUALITY

Continued Improvements Needed in CMS's Data and Oversight

Statement of John E. Dicken, Director, Health Care

GAO Highlights

Highlights of GAO-18-594T, a testimony before the Subcommittee on Oversight and Investigations, Committee on Energy and Commerce, House of Representatives

Why GAO Did This Study

Approximately 15,500 nursing homes participating in the Medicare and Medicaid programs provide care to 1.4 million residents—a population of elderly and disabled individuals. To help ensure nursing home residents receive quality care, CMS defines quality standards that homes must meet to participate in the Medicare and Medicaid programs. To monitor compliance with these standards, CMS enters into agreements with state survey agencies to conduct on-site surveys of the state's homes and also collects other data on nursing home quality.

Although CMS and others have reported some potential improvements in nursing home quality, questions have been raised about nursing home quality and weaknesses in CMS oversight.

This statement summarizes GAO's October 2015 report, GAO-16-33. Specifically, it describes (1) trends in nursing home quality through 2014, and (2) changes CMS had made to its oversight activities as of October 2015. It also includes the status of GAO's recommendations associated with these findings. GAO recently obtained information from CMS officials about steps they have taken to implement the 2015 GAO recommendations.

View GAO-18-594T. For more information, contact John Dicken at (202) 512-7114 or dickenj@gao.gov.

September 2018

NURSING HOME QUALITY

Continued Improvements Needed in CMS's Data and Oversight

What GAO Found

GAO's October 2015 report found mixed results in nursing home quality based on its analysis of trends reflected in key sources of quality data that the Centers for Medicare & Medicaid Services (CMS) collects.

- An increase in reported consumer complaints suggested that consumers' concerns about nursing home quality increased.
- In contrast, trends in care deficiencies, nurse staffing levels, and clinical quality measures indicated potential improvement in nursing home quality.

GAO also found that data issues complicated CMS's ability to assess nursing home quality trends. For example:

- CMS allowed states to use different survey methodologies to measure deficiencies in nursing home care, which complicates the ability to make comparisons nationwide. GAO recommended that CMS implement a standardized survey methodology across states, and in November 2017 CMS completed national implementation.
- CMS did not regularly audit selected quality data including nurse staffing and clinical data (for example, on residents with pressure ulcers) to ensure their accuracy. GAO recommended CMS implement a plan for ongoing auditing of quality data. The agency concurred with this recommendation and has been conducting regular audits of nurse staffing data but does not have a plan to audit other quality data on a continuing basis. GAO continues to believe that regular audits are needed to ensure the accuracy and comparability of nursing home quality data.

GAO's October 2015 report found that CMS had made numerous modifications to its nursing home oversight activities. However, CMS had not monitored how the modifications might affect its ability to assess nursing home quality. GAO found that some modifications expanded or added new activities—such as creating new training for state surveyors on unnecessary medication usage—while others reduced existing activities. For example, CMS reduced the number of nursing homes participating in the Special Focus Facility program—which provides additional oversight of certain homes with a history of poor performance—by over half from 2013 to 2014. CMS officials told GAO that some of the reductions to oversight activities were in response to an increase in oversight responsibilities and a limited number of staff and financial resources. To help ensure modifications do not adversely affect CMS's ability to assess nursing home quality, GAO recommended that CMS monitor modifications of essential oversight activities to better understand the effects on nursing home quality oversight. CMS concurred with this recommendation and told us it has begun to take steps to address it. Such monitoring is important for CMS to better understand how its oversight modifications affect nursing home quality and to improve its oversight given limited resources.

Chairman Harper, Ranking Member DeGette, and Members of the Subcommittee:

I'm pleased to be here today to discuss our work on nursing home quality and the Centers for Medicare & Medicaid Services' (CMS) oversight of nursing homes. Nationwide, approximately 15,600 nursing homes provide care to about 1.4 million nursing home residents—a population of elderly and disabled individuals. To help ensure this population receives quality care, CMS defines the quality standards nursing homes must meet in order to participate in the Medicare and Medicaid programs.¹ To monitor compliance with these standards, CMS enters into agreements with state survey agencies to conduct required surveys, or evaluations, of the state's nursing homes.

For many years, we and the Department of Health and Human Services (HHS) Office of the Inspector General (OIG) have reported on problems in nursing home quality and on weaknesses in CMS's oversight.² As early as 1998, GAO reported on residents in California nursing homes who received unacceptable care that sometimes endangered their health and safety.³ In the intervening two decades, across more than 20 reports, GAO has repeatedly reported on shortcomings both in the care some nursing home residents received and in the federal and state oversight of nursing home care. For example, a 1999 report found that complaint investigation processes were often inadequate to protect residents, and a 2008 report found federal oversight continued to demonstrate that state inspections understated serious care problems.⁴ In response to identified weaknesses, CMS and state survey agencies have made some changes

¹Medicaid, a federal-state health financing program for low-income and medically needy individuals, is the nation's primary payer of long-term services and supports for children and adults with disabilities and aged individuals. Medicare, the federal health insurance program for people age 65 and older, individuals under age 65 with certain disabilities, and individuals diagnosed with end-stage renal disease, covers some short-term skilled nursing and rehabilitative care for beneficiaries following an acute care hospital stay.

²See, for example, OIG, *Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries*, OEI-06-11-00370 (Washington, D.C.: Feb. 2014).

³See GAO, *California Nursing Homes: Care Problems Persist Despite Federal and State Oversight*, GAO/HEHS-98-202 (Washington, D.C.: July 27, 1998).

⁴See GAO, *Nursing Homes: Complaint Investigation Processes Often Inadequate to Protect Residents*, HEHS-99-80 (Washington, D.C.: Mar. 22, 1999) and *Nursing Homes: Federal Monitoring Surveys Demonstrate Continued Understatement of Serious Care Problems and CMS Oversight Weaknesses*, GAO-08-517 (Washington, D.C.: May 9, 2008).

in how they conduct oversight of nursing home quality, and some potential improvements in nursing home quality have been reported in recent years. For example, CMS has reported a decrease in the percentage of homes that were cited for serious health deficiencies from 2006 to 2014.⁵ In addition, CMS and others have reported on improvements in specific nursing home clinical measures, such as reductions in the use of physical restraints, which can be a sign of improved quality of care.

However, as you know, news stories and reports continue to identify potential problems in nursing homes. For example, a July 2018 article from *Kaiser Health News* highlighted that new data collected by CMS to evaluate nurse staffing showed most nursing homes had fewer nurses and caretaking staff than they had previously reported to CMS, with frequent and significant fluctuations in day-to-day staffing.⁶ As part of its ongoing work, the OIG determined CMS does not have adequate procedures in place to ensure incidents of potential abuse or neglect of Medicare beneficiaries in nursing homes are identified and reported.⁷ In light of these concerns and a delay in enforcement of 2016 long-term care regulatory reforms, as well as a reduction in civil money penalties for non-compliance with federal health and safety requirements, 17 state attorneys general sent a letter urging CMS to implement the strengthened regulations and maintain penalties for non-compliance in May 2018.⁸

⁵CMS, *Nursing Home Data Compendium 2015 Edition*.

⁶J. Rau, "Like a Ghost Town: Erratic Nursing Home Staffing Revealed Through New Records," *Kaiser Health News*, July 13, 2018, accessed August 27, 2018, <https://khn.org/news/like-a-ghost-town-erratic-nursing-home-staffing-revealed-through-new-records/>.

⁷See Daniel R. Levinson, OIG, HHS, memorandum to Seema Verma, Administrator, CMS, *Early Alert: The Centers for Medicare & Medicaid Services Has Inadequate Procedures To Ensure That Incidents of Potential Abuse or Neglect at Skilled Nursing Facilities Are Identified and Reported in Accordance With Applicable Requirements*, A-01-17-00504 (Aug. 24, 2017).

⁸Attorneys General of California, Connecticut, the District of Columbia, Hawaii, Illinois, Iowa, Maryland, Massachusetts, Minnesota, Mississippi, New York, Oregon, Pennsylvania, Rhode Island, Vermont, Virginia, and Washington, letter to the Secretary of Health and Human Services and Administrator of CMS, *Regulation of Skilled Nursing Facilities* (May 30, 2018).

To help inform today's discussion, my testimony will focus on the findings from our October 2015 report examining CMS's oversight of nursing home quality.⁹ In particular, this statement will address:

1. trends in nursing home quality through 2014, and
2. changes CMS had made to its oversight activities as of October 2015.

In addition, I will highlight key actions that we recommended HHS take, including HHS's response and the current status of those recommendations.

While my comments today focus on the findings of our October 2015 report, they are also informed by our large body of work examining nursing home quality. (See Appendix I for a list of related GAO reports.)

In our October 2015 report, we analyzed four key sets of quality data from CMS using the most recent data available at that time. We also reviewed relevant oversight and data documents and interviewed officials from CMS central office, CMS regional offices, and state survey agencies for a selected group of states. The 2015 report includes a full description of our scope and methodology. We also obtained information from CMS on the status of our 2015 recommendations, as of 2018. We conducted the work on which this statement is based in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Oversight of nursing homes is a shared federal-state responsibility, with CMS central and regional offices overseeing activities completed by state survey agencies. Specifically, CMS central office (1) oversees the federal quality standards nursing homes must meet to participate in the Medicare and Medicaid programs and (2) establishes the responsibilities of CMS's regional offices and state survey agencies to ensure federal quality standards for nursing homes are met. CMS regional offices oversee state activities and report results back to CMS central office. Specifically, regional offices are required to conduct annual federal monitoring surveys

⁹See GAO, *Nursing Home Quality: CMS Should Continue to Improve Data And Oversight*, GAO-16-33 (Washington, D.C.: Oct. 30, 2015).

to assess the adequacy of surveys conducted by state survey agencies. CMS regional offices also evaluate state surveyors' performance on factors such as the frequency and quality of state surveys. Finally, in each state, under agreement with CMS, a state survey agency assesses whether nursing homes meet CMS's standards by conducting regular surveys and investigations of complaints regarding resident care or safety, as needed.

CMS collects data on nursing home quality through annual standard surveys and complaint investigations, as well as other sources, such as staffing data and clinical quality measures.

- **Standard surveys.** By law, every nursing home receiving Medicare or Medicaid payment must undergo a standard survey during which teams of state surveyors conduct a comprehensive on-site evaluation of compliance with federal quality standards.¹⁰ Nursing homes with consistently poor performance can be selected for the Special Focus Facility (SFF) program, which requires more intensive oversight, including more frequent surveys.¹¹
- **Complaint investigations.** Nursing homes also are surveyed on an as-needed basis with investigations of consumer complaints. These complaints can be filed with state survey agencies by residents, families, ombudsmen, or others acting on a resident's behalf. During an investigation, state surveyors evaluate the nursing home's compliance with a specific federal quality standard.
- **Staffing data.** Nurse staffing levels are considered a key component of nursing home quality and are often measured in total nurse hours

¹⁰For most deficiencies identified during surveys, a home is required to prepare a plan of correction, and, depending on the severity of the deficiency, surveyors may conduct a revisit to ensure that the nursing home has implemented its plan and corrected the deficiency. The scope and severity of a deficiency determine the enforcement actions—such as requiring training for staff, imposing monetary penalties, or termination from the Medicare and Medicaid programs.

¹¹According to CMS guidance, SFF nursing homes that fail to significantly improve after three standard surveys, or about 18 months, may be involuntarily terminated from Medicare and Medicaid. The SFF program is statutorily required, and CMS is mandated to conduct its SFF program for homes that have "substantially failed" to meet applicable requirements of the Social Security Act. For more information on the SFF program, see GAO, *Poorly Performing Nursing Homes: Special Focus Facilities Are Often Improving, but CMS's Program Could Be Strengthened*, GAO-10-197 (Washington, D.C.: Mar. 19, 2010).

per resident day. Higher nurse staffing levels are typically linked with higher quality nursing home care.

- **Clinical quality measures.** Nursing homes are required to provide data on certain clinical quality measures—such as the incidence of pressure ulcers—for all residents to CMS. CMS currently tracks data for 18 clinical quality measures.

CMS publicly reports a summary of each nursing home's quality data on its Nursing Home Compare website using a five-star quality rating.¹² The Five-Star Quality Rating System assigns each nursing home an overall rating and three component ratings—surveys (standard and complaint), staffing, and quality measures—based on the extent to which the nursing home meets CMS's quality standards and other measures. In a 2016 report, we found that CMS did not have a systematic process for prioritizing recommended changes to improve its Nursing Home Compare website and that several factors limited the ability of CMS's Five-Star Quality Rating System to help consumers understand nursing home quality and choose a home. We recommended that CMS establish a process to evaluate and prioritize website improvements and add explanatory information about the Five-Star System to Nursing Home Compare. HHS agreed and in 2018 completed actions on these recommendations, but has not yet acted on the other recommendations, including providing national comparison information that we maintain are important to help enable consumers to understand nursing home quality and make distinctions between nursing homes.

¹²See GAO, *Nursing Homes: Consumers Could Benefit from Improvements to the Nursing Home Compare Website and Five-Star Quality Rating System*, GAO-17-61 (Washington, D.C.: Nov. 18, 2016) and *Health Care Transparency: Actions Needed to Improve Cost and Quality Information for Consumers*, GAO-15-11 (Washington, D.C.: Oct. 20, 2014).

Nursing Home Quality Data Show Mixed Results, Although Data Issues Complicate Ability to Assess Quality Trends

In our October 2015 report examining trend data that give insight into nursing home quality, we found that four key data sets showed mixed results, and data issues complicated the ability to assess quality trends.

Data on Nursing Home Quality Showed Mixed Results

Nationally, one of the four data sets—consumer complaints—suggested consumers' concerns over nursing home quality increased from 2005 to 2014. However, the other three data sets—deficiencies, staffing levels, and clinical quality measures—indicated potential improvement in nursing home quality (see Table 1). Specifically, we found consumer complaints—which can originate from residents, families, ombudsmen, or others acting on a resident's behalf—had a 21 percent increase from 2005 to 2014. In contrast, nurse staffing levels increased 9 percent from 2009 to 2014 and selected quality measure scores showed decreases in the number of reported quality problems, such as falls resulting in major injury from 2011 to 2014.

Table 1: Overview of Trends in Key Nursing Home Quality Data

Quality data	Description	Time period	Change ^a
Consumer complaints	Average number of consumer complaints reported per nursing home	2005-2014	Increase in complaints (21%)
Deficiencies cited on standard surveys	Average number of serious deficiencies—deficiencies that, at a minimum, caused harm to the resident cited per nursing home surveyed	2005-2014	Decrease in serious deficiencies (41%)
Nurse staffing	Average total nurse hours per resident day ^b	2009-2014	Increase in nurse hours (9%)
Selected quality measures	Nursing homes' scores on 8 of CMS's clinical nursing home quality measures ^c	2011-2014	Decrease in quality problems (varied by measure)

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data. | GAO-18-694T

^aSpecifically, from 2005 through 2014, the average number of consumer complaints reported per nursing home increased nationally from 3.2 to 3.9. From 2005 through 2014, the number of serious deficiencies cited per nursing home surveyed decreased nationally from 0.35 to 0.21. From 2009 through 2014, the average total nurse hours per resident per day increased nationally from 4.2 to 4.6. From 2011 through 2014, nationwide nursing homes' scores on all 8 of our selected quality measures improved, at least somewhat, but the rate of decline varied greatly by quality measure. For example, the percentage of long-stay residents with too much weight loss decreased 1.3 percent over the 4-

year period, while the percentage of short-stay residents with new or worsening pressure ulcers decreased 52.2 percent.

¹²The average total nurse hours per resident per day is a measure of registered nurse, licensed practical nurse, and nurse assistant hours. At the time of our 2015 report this measure was based on the number of hours worked that nursing homes self-reported; as of July 2016, these measures were based on payroll and other verifiable data submitted to CMS by the homes.

¹³The selected quality measures include the percentage of long-stay residents who report moderate to severe pain; the percentage of long-stay, high-risk residents with pressure ulcers; the percentage of long-stay residents who lose too much weight; the percentage of long-stay residents who were physically restrained; the percentage of long-stay residents experiencing one or more falls with major injury; the percentage of long-stay residents who received antipsychotic medication; the percentage of short-stay residents who report moderate to severe pain; and the percentage of short-stay residents with pressure ulcers that are new or worsening.

In addition, we identified 416 homes in 36 states that had consistently poor performance across the four data sets we examined. Of the 416 homes, 71 (17 percent) were included in the Special Focus Facility (SFF) program at some point between 2005 and 2014.

Data Issues Complicated CMS's Ability to Assess Quality Trends

In our October 2015 report, we found CMS's ability to use available data to assess nursing home quality trends was complicated by various issues with these data, which made it difficult to determine whether observed trends reflect actual changes in quality, data issues, or both. CMS has taken some actions to address these data complications, however, more work is needed.

Consumer complaints: The average number of consumer complaints reported per nursing home increased in the 10 years of data we examined, although it is unclear to what extent this can be attributed to a change in quality or to state variation in the recording of complaints. Some state survey agency officials explained that changes in how they recorded complaints into CMS's complaint tracking system could in part account for the jump in reported complaints. In addition, officials at one state survey agency explained the increase in complaints could also reflect state-level efforts to provide consumers with more user-friendly options for filing complaints. Similarly, in April 2011, we found differences in how states record and track complaints.¹³

¹³See GAO, *Nursing Homes: More Reliable Data and Consistent Guidance Would Improve CMS Oversight of State Complaint Investigations*, GAO-11-280 (Washington, D.C., Apr. 7, 2011).

Deficiencies cited on standard surveys: The decline in the number of serious deficiencies—deficiencies that at a minimum caused a harm to the resident—in the data we examined may have indicated an improvement in quality, although it may also be attributed to inconsistencies in measurement. For example, the use of multiple survey types, such as both traditional paper-based surveys and electronic surveys, to conduct the standard survey that every nursing home receiving Medicare or Medicaid payment must undergo complicates the ability to compare the results of these surveys nationally.¹⁴ In our October 2015 report, we recommended CMS implement the same survey methodology across all states; HHS agreed with this recommendation and in November 2017 completed its national implementation of this electronic survey methodology.¹⁵

Nurse staffing: CMS data showed the average total nurse hours per resident day increased from 2009 through 2014, although CMS did not have assurance these data were accurate. Many of the regional office and state survey agency officials we spoke with expressed concern over the self-reported nature of these data, noting that it may be easy to misrepresent nurse staff hours. At the time of our 2015 report, CMS was in the process of implementing a system to collect staffing information based on payroll and other verifiable data and has now completed that implementation, as required by law. We recommended in 2015 that CMS establish and implement a clear plan for ongoing auditing of its staffing data and other quality data. HHS agreed with this recommendation and in July 2018 CMS provided us with documentation that it was conducting regular audits of this new nurse staffing data. According to CMS, facilities experienced challenges submitting complete and accurate data in the early stages, however, as of April 2018 the agency has begun relying on

¹⁴Some regional offices and state survey agencies we spoke to for the October 2015 report noted electronic surveys result in fewer deficiencies cited, especially for more serious deficiencies and deficiencies related to quality of care. Thus, the decreasing trend of serious deficiencies could be the result of an expanding use of electronic surveys, rather than an improvement in the quality of nursing homes.

¹⁵CMS, letter to State Survey Agency Directors, *Revision to State Operations Manual (SOM) Appendix PP for Phase 2, F-Tag Revisions, and Related Issues*, S&C: 17-36-NH (June 30, 2017).

the payroll data to calculate the staffing measures that it posts in Nursing Home Compare and uses in the Five-Star Quality Rating System.¹⁶

Selected quality measures: Nursing homes generally improved their performance on the eight selected quality measures we reviewed, although it is unclear to what extent this can be attributed to a change in quality or possible inaccuracies in self-reported data. Like the nurse staffing data used by CMS, data on nursing homes' performance on these measures were self-reported, and until 2014 CMS conducted little to no auditing of these data to ensure their accuracy. In our 2015 report, we found CMS had begun taking steps to help mitigate the problem with self-reported data by starting to audit the data in 2015; however, the agency did not have clear plans to continue the audits beyond 2016. As such, in our recommendation we indicated the need for ongoing auditing of data used to calculate clinical quality measures. As of August 2018, CMS has not provided us a plan for ongoing auditing of its clinical quality measures and we continue to believe that CMS should establish and carry out such a plan.

Collectively, these data issues have broader implications related to nursing home quality trends, including potential effects on the quality benchmarks CMS sets and consumers' decisions about which nursing home to select.¹⁷ Furthermore, data used by CMS to assess quality measures are also used when determining Medicare payments to nursing homes, so data issues—and CMS's internal controls related to the data—could affect the accuracy of payments. Moreover, the use of quality data for payment purposes will expand in fiscal year 2019 when a nursing home value-based purchasing program will be implemented, which will increase or reduce Medicare payments to nursing homes based on certain quality measures.

¹⁶See CMS, letter to State Survey Agency Directors, *Transition to Payroll-Based Journal (PBJ) Staffing Measures on the Nursing Home Compare Tool on Medicare.gov and the Five Star Quality Rating System* (April 6, 2018, QSO-18-17-NH).

¹⁷In our 2016 report on CMS's Nursing Home Compare and Five-Star Quality Rating System, we reviewed the extent to which the rating system—which is based on these data sets—enables consumers to understand nursing home quality and make distinctions between homes. See GAO-17-61.

CMS Had Modified Oversight Activities by 2015, But Had Not Monitored Potential Effect on Nursing Home Quality Oversight

Our 2015 report found that CMS had made numerous modifications to its nursing home oversight activities in recent years, but had not monitored the potential effect of these modifications on nursing home quality oversight. Some of these modifications expanded or added new oversight activities—for example, CMS expanded the number of tools available to state surveyors when investigating medication-related adverse events, increased the amount of nursing home quality data available to the public, and created new trainings for surveyors on unnecessary medication usage.¹⁸ However, other modifications reduced existing oversight activities.

In 2015, we highlighted modifications that reduced two existing oversight activities—the federal monitoring survey program and the SFF program.

- **Federal monitoring surveys:** CMS reduced the scope of the federal monitoring surveys regional offices use to evaluate state surveyors' skills in assessing nursing home quality. CMS requires regional offices to complete federal monitoring surveys in at least 5 percent of nursing homes surveyed by the state each year. Starting in 2013, CMS required fewer federal monitoring surveys to be standard surveys and allowed more monitoring surveys to be the narrower scoped and less-resource intensive revisits and complaint investigations.¹⁹
- **Special Focus Facilities:** CMS reduced the number of nursing homes participating in the SFF program.²⁰ In 2013, CMS began to reduce the number of homes in the program by instructing states to terminate homes that had been in the program for 18 months without improvement from participating in Medicare and Medicaid. As we have previously reported, between 2013 and 2014, the number of nursing homes in the SFF program dropped by more than half—from 152 to 62. In 2014, CMS began the process of re-building the number

¹⁸See GAO-16-33 for additional information on oversight modifications made.

¹⁹Before 2013, CMS required 80 percent of these federal monitoring surveys be standard surveys—the most comprehensive type—which cover a broad range of quality issues within a nursing home. The remaining 20 percent of surveys were permitted to be either revisit or complaint surveys, which are more narrow in scope and are also less-resource intensive.

²⁰Nursing homes placed in the SFF program receive additional oversight because of the homes' history of poor performance. If homes do not improve the quality of their care, CMS can terminate their participation in Medicare and Medicaid.

of facilities in the SFF program; however, according to CMS officials, the process would be slow, and as of August 2018 there were 85 SFFs.

In 2015, CMS said some of the reductions to oversight activities were in response to an increase in oversight responsibilities and limited number of staff and financial resources. Specifically, CMS officials said increasing oversight responsibilities and a limited number of staff and financial resources at the central, regional, and state levels required the agency to evaluate its activities and reduce the scope of some activities. In the October 2015 report, we recommended CMS monitor oversight modifications to better assess their effects; HHS agreed with the recommendation and told us they are beginning to take steps to address this issue. We maintain the importance of monitoring to help CMS better understand how its oversight modifications affect nursing home quality and to improve its oversight given limited resources.²¹

Chairman Harper, Ranking Member DeGette, and Members of the Subcommittee, this concludes my prepared statement. I would be pleased to respond to any questions that you may have at this time.

GAO Contact and Staff Acknowledgments

For further information about this statement, please contact John E. Dicken at (202) 512-7114 or dickenj@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this testimony. In addition to the contact named above, key contributors to this statement were Karin Wallestad (Assistant Director), Sam Amrhein, Summar Corley, Pam Dooley, Will Simerl, and Jennifer Whitworth.

²¹Under federal internal control standards, ongoing monitoring should occur in the course of normal program operations. See GAO, *Standards for Internal Control in the Federal Government*, GAO/AIMD-00-21.3.1 (Washington, D.C.: Nov. 1999).

**Appendix I: Related
GAO Reports**

Nursing Homes: Consumers Could Benefit from Improvements to the Nursing Home Compare Website and Five-Star Quality Rating System. GAO-17-61. Washington, D.C.: November 18, 2016.

Skilled Nursing Facilities: CMS Should Improve Accessibility and Reliability of Expenditure Data. GAO-16-700. Washington, D.C.: September 7, 2016.

Nursing Home Quality: CMS Should Continue to Improve Data and Oversight. GAO-16-33. Washington, D.C.: October 30, 2015.

Health Care Transparency: Actions Needed to Improve Cost and Quality Information for Consumers. GAO-15-11. Washington, D.C.: October 20, 2014.

Nursing Homes: More Reliable Data and Consistent Guidance Would Improve CMS Oversight of State Complaint Investigations. GAO-11-280. Washington, D.C.: April 7, 2011.

Nursing Homes: Complexity of Private Investment Purchases Demonstrates Need for CMS to Improve the Usability and Completeness of Ownership Data. GAO-10-710. Washington, D.C.: September 30, 2010.

Poorly Performing Nursing Homes: Special Focus Facilities Are Often Improving, but CMS's Program Could Be Strengthened. GAO-10-197. Washington, D.C.: March 19, 2010.

Nursing Homes: Addressing the Factors Underlying Understatement of Serious Care Problems Requires Sustained CMS and State Commitment. GAO-10-70. Washington, D.C.: November 24, 2009.

Nursing Homes: Opportunities Exist to Facilitate the Use of the Temporary Management Sanction. GAO-10-37R. Washington, D.C.: November 20, 2009.

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. Washington, D.C.: August 28, 2009.

Medicare and Medicaid Participating Facilities: CMS Needs to Reexamine Its Approach for Funding State Oversight of Health Care Facilities. GAO-09-64. Washington, D.C.: February 13, 2009.

Nursing Homes: Federal Monitoring Surveys Demonstrate Continued Understatement of Serious Care Problems and CMS Oversight Weaknesses. GAO-08-517. Washington, D.C.: May 9, 2008.

Nursing Homes: Efforts to Strengthen Federal Enforcement Have Not Deterred Some Homes from Repeatedly Harming Residents. GAO-07-241. Washington, D.C.: March 26, 2007.

Nursing Homes: Complaint Investigation Processes Often Inadequate to Protect Residents. GAO/HEHS-99-80. Washington, D.C.: March 22, 1999.

California Nursing Homes: Care Problems Persist Despite Federal and State Oversight. GAO/HEHS-98-202. Washington, D.C.: July 27, 1998.

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Mr. HARPER. Thank you, Mr. Dicken.

This is now the members' opportunity to ask questions of each of you to learn more about this very important issue, so I will recognize myself for 5 minutes.

Ms. Dorrill, HHS OIG has identified improving care for vulnerable populations including the care provided to individuals in nursing homes as a top management challenge for a decade. Could you expand on this and tell us why ensuring nursing home residents receive the proper standard of care continues to be such a longstanding challenge for HHS and specifically CMS?

Ms. DORRILL. Yes, thank you for the question. It certainly is true that we have considered this a top management challenge for years and we would love to have that removed from the list. But unfortunately the problems remain. And I think it is important to note that although so many of these problems are longstanding that we are in a different place in time so the heavy lift with revising recommendations that has been done, when I said in my statement that we have a framework I think that's correct. And so we are at a different place than we were when we cited those TMCs over the years.

Mr. HARPER. Is that a better place?

Ms. DORRILL. Yes. I think it's a first step, absolutely. And that but the proof will be in the execution of that, that sometimes a requirement and the actions of the homes just like emergency planning can be miles apart. And so, but that first step was an enormous one and an important one. And so we would hope as we see execution over the next couple of years that we might be able to eliminate this concern from our top management challenges.

Mr. HARPER. Do you see now that you and CMS are all on the same page?

Ms. DORRILL. It's a great question, yes and no. Yes, on some factors we feel that in respect to our adverse events the harm from medical care that CMS has been proactive in they pulled us into the process of providing that guidance based on our expertise and have laid out very explicit instructions for nursing homes and surveyors. In other areas I wouldn't grade them as highly.

Mr. HARPER. Mr. Dicken, I would like to ask you a similar question. Given GAO's substantial body of work examining Federal efforts related to nursing home quality of care, have any issues stood out to you as being long-term challenges for CMS?

Mr. DICKEN. Yes, thank you. And I think as you note that we do have a long-term body of work and many of those same types of issues have occurred. We are pleased that over the years CMS has implemented many of the recommendations we've had and made a number of changes. Certainly we've seen improvements in things like training of surveyors, a more standardized methodology for surveyors. We do continue to see that there's important need to make sure that information that CMS is receiving is accurate and that they're using it for assessing States consistently.

And very important that as there are a number of changes occurring over the years that CMS and others continue to monitor to see what the effects of those changes actually are, both in some of the improvements and the enhancements that have been made as well as some of the reductions in oversight that have been made.

Mr. HARPER. All right. Let me just follow up on that just a little bit if I can. Are there any aspects of CMS' efforts relating to nursing homes that GAO's work may have touched on would you believe merit additional attention?

Mr. DICKEN. Well, we do still have a number of open recommendations that CMS has taken some steps in, one, in trying to make sure the information's more accurate. I think Dr. Goodrich mentioned that they have now much more verifiable information on staffing and are using that to more thoroughly look at and use inspections of staffing.

There are other areas still, however, where they still need to make sure that getting accurate information and of monitoring those effects.

Mr. HARPER. And, Dr. Goodrich, if I can ask you a question. Obviously in my opening statement I mentioned the terrible tragedy in Florida at Hollywood Hills at the Rehabilitation Center. And I know CMS terminated the facility from Medicare and Medicaid and has obviously recognized how horrible that is.

The owner of the facility still has an ownership interest in 11 other facilities. Under CMS' current authority, is there anything preventing him from opening a new or additional nursing home facility?

Dr. GOODRICH. So thank you for the question. The tragedy at Hollywood Hills was just that, devastating tragedy that should never have happened. As has been said before, it was a complete management failure. As I understand the facts of this case, there's nothing in Medicare that prevents Dr. Michel—if I'm saying his name right—

Mr. HARPER. Yes.

Dr. GOODRICH [continuing]. From having ownership interest in Medicare facilities. Medicare can only bar an individual who has been convicted of a felony or who is on the OIG exclusion list.

Mr. HARPER. In light of Dr. Michel's history, do you believe you need additional tools that can restrict based upon something less than a criminal conviction?

Dr. GOODRICH. So this is not my exact area, but I am aware that CMS issued a proposed rule in 2016 to further enhance our program integrity abilities related to this area. We received a number of comments on that rule and we are currently considering them in terms of how to move forward.

Mr. HARPER. Thank you, Dr. Goodrich.

The chair will now recognize Ranking Member DeGette for 5 minutes.

Ms. DEGETTE. Thank you.

Ms. Dorrill mentioned that updating the recommendations is going to be the first step to trying to solve this problem. And as I mentioned in my opening statement, in 2016 CMS issued regulations that updated the Federal health and safety rules for nursing homes.

I know, Dr. Goodrich, that CMS is now in the process of implementing those regulations. I think the one you just referred to is probably one of them. You said that in your testimony these changes are the first comprehensive updates of the nursing home regulations since 1991; is that right? Yes Dr. Goodrich.

Dr. GOODRICH. Sorry. That is correct.

Ms. DEGETTE. And so I am assuming that a lot has changed in the industry that would necessitate an update to those rules and I would assume that the 2016 regulations were designed in part to reflect the advancements and improve how the industry provides quality care to nursing home residents; is that correct?

Dr. GOODRICH. Yes, that is correct.

Ms. DEGETTE. And as I said in my opening statement, since the rules have been finalized CMS has taken several actions that could delay some of them or roll them back altogether. First of all, the rules were designed to be implemented in phases, but not all the phases have been implemented yet.

Second, CMS now has issued a moratorium on enforcing some of those rules, and, finally, last year CMS launched a review of nursing home regulations to or requirements to determine whether any of them placed procedural burdens on facilities. So it sounds like maybe some of these proposed rules will never be implemented; is that correct?

Dr. GOODRICH. We are currently in the process as you mentioned of implementing the rule that we finalized in 2016. We are on target for implementing all three of the phases and that is underway now.

Ms. DEGETTE. OK. And what is your timeframe for implementing all of the phases?

Dr. GOODRICH. So phase 1 was implemented shortly after the publication of the final rule in 2016. This was really the things that nursing homes were already doing or were very simple to achieve.

Ms. DEGETTE. OK.

Dr. GOODRICH. Phase 2, we began implementation and surveying and enforcing on November 28th of 2017, so that is underway now. We've surveyed about—

Ms. DEGETTE. It has been about a year.

Dr. GOODRICH. It's been about a year and phase 3 begins in November of 2019.

Ms. DEGETTE. And how long will that take?

Dr. GOODRICH. So nursing homes are expected to be compliant with the phase 3 requirements by November of 2019. So at that time that will be the expectation.

Ms. DEGETTE. OK. And so let me just ask the question again. Do you anticipate that all of the 2016 rules will be implemented?

Dr. GOODRICH. Yes, we are on track to implement the 2016 final rule.

Ms. DEGETTE. OK. Now I want to ask you a question about a CMS proposal that might prohibit nursing home residents from being able to bring a lawsuit. There is a rule that bans pre-dispute arbitration agreements and CMS has signaled it may remove it. In other words CMS is proposing to remove what I consider to be a consumer protection rule that was designed to make sure that nursing home residents could go to court or could join other people in lawsuits to settle grievances and that they wouldn't be forced into arbitration.

I know a lot of groups like the AARP have expressed concerns about this proposed change. What is the status of that? Does CMS intend to do that and why?

Dr. GOODRICH. So as you mentioned as part of the 2016 final rule we did impose a ban on pre-dispute arbitration.

Ms. DEGETTE. Yes.

Dr. GOODRICH. Shortly thereafter, Department of Health and Human Services was sued for an injunction, a preliminary and permanent injunction to stop CMS from enforcing that ban on pre-dispute arbitration. The court granted a preliminary injunction in November of 2016, so we currently cannot enforce what we finalized—

Ms. DEGETTE. Did by court order?

Dr. GOODRICH. Yes.

Ms. DEGETTE. And what is the status of that lawsuit, do you know?

Dr. GOODRICH. I'm not certain of the status but the injunction is still in place so we are not able to enforce.

Ms. DEGETTE. If you could get us the status of that lawsuit that would be—

Dr. GOODRICH. Certainly.

Ms. DEGETTE [continuing]. Very helpful to us because my view and I think Congresswoman Schakowsky would really agree with me about this as one of the most effective ways to address if we see rampant nursing home abuses is when patients can bring class actions against some of these bad actors. And, you know, these families they are going into nursing homes, they are being asked to sign these arbitration agreements. They are so desperate to get the health—as I think all of you have said, these are families in crisis many times and so they just sign it and then they have signed away their legal rights.

So we will do everything we can, I think, to make sure that we can enforce that 2016 rule that people don't have to be forced to sign arbitration agreements. With that I yield back.

Mr. HARPER. The gentlewoman yields back.

The chair will now recognize the gentleman from Oregon, the chair of the full committee, Mr. Walden, for 5 minutes.

Mr. WALDEN. Thank you, Mr. Chairman. And I want to thank our witnesses. We have another hearing going on downstairs and so some of us have to bounce back and forth.

Dr. Goodrich, a September 2017 data brief issued by the OIG indicated that there was a significant amount of variation with respect to how state survey agencies classified the complaints they received. For example, data compiled by the OIG showed that in 2015 there were three States that prioritized complaints as being immediate jeopardy at least 40 percent of the time, while eight States did not designate any of their complaints as immediate jeopardy.

Can you explain why there seems to be such a variation in how States prioritize complaints and what is CMS doing to ensure that complaints and deficiencies are addressed in a more consistent manner?

Dr. GOODRICH. Yes, thank you for the question. So, first, I want to say we very much appreciate the work of the OIG and the GAO in the oversight of our programs. They really help to make our programs better and we have concurred with the vast majority of their

recommendations particularly on this issue around state service oversight, state agency oversight.

So we are undertaking actively a number of actions to address exactly these recommendations. So number one, CMS regional offices do meet quarterly with the state survey agencies to discuss issues, look at trends and how they're performing, any concerns that they may have. We also recently undertook an effort to really overhaul our Federal oversight surveys.

We are required to conduct Federal oversight surveys of about five percent of state surveys or at least five state surveys and we've been doing this for awhile, but we've undertaken an effort beginning in April of this year to revise that process in response to what we learned from the OIG as well as the GAO. So that's underway now as well.

We also give monthly feedback reports to the state survey agencies that we began in April of this year which allow them to understand where their own deficiencies are, where there may be patterns of inconsistencies or where they're not appropriately citing deficiencies as they should. And this has really been made possible by the new standardized software-based survey process that we implemented last fall across the country.

Mr. WALDEN. Ah, OK.

Dr. GOODRICH. And then finally we are in the process right now of really overhauling the State Performance Standards System. This is a system that we've had underway for awhile, but again in response to the recommendations from the OIG and the GAO we began an effort again in April of this year to evaluate this entire program to identify ways to improve it. It's a very large-scale effort, will take at least a year to do but is well underway. And it's really focused on improving the efficiency and the effectiveness of measuring and improving state performance.

Mr. WALDEN. Right.

Dr. GOODRICH. So we're very happy that we have these recommendations and that we're moving forward on them.

Mr. WALDEN. Good, thank you. Admittedly, this is old, but my mother spent her last few months in a nursing home in our hometown 28 years ago. And I spent a lot of time in and out as you do with a parent and I was always struck by how much time the people that were giving health care had to spend on paperwork. And they would be off in the cafeteria and I went over, and I was in state legislature at the time, and I said what is all this, and just reams of paper, paper, paper.

And I thought at some point, here, as public policy people we want what everybody wants is quality safe care especially for this vulnerable and difficult fragile population and sometimes government just overreacts and says we need a new rule, we need a new regulation, we need another something which in the end eats up the resource that is hard to get.

It is hard to, as we all know there are medical shortages in terms of nurses and aides and everybody else and it just struck me that would my mother have been better off with less reporting and paperwork and somebody that actually was checking on her more often. Do you know what I mean? And we have got to have both, it is finding this right balance. But boy, I hope somebody is looking

at just the layer, a layer, a layer we tend to add on to address a single problem that may occur in Florida and so we think we have to do this everywhere.

And looks at are there some things that we could peel back that would actually allow improved quality of care and then what are the real management tools we need and make sure they are being enforced effectively in this process. It is hard, I know, but I have seen it firsthand. My parents, both my parents and my mother-in-law and over the years and, you know, you realize it is a difficult population and very fragile medically. Things happen and mistakes are made and there are some bad actors.

And so I just hope as you all are doing your work somebody is looking at that angle as well so the measurements and the tools for enforcement are effective but make sense too. So, Mr. Chairman, I yield back.

Mr. HARPER. The gentleman yields back. The chair will now recognize the gentlewoman from Florida, Ms. Castor, for 5 minutes.

Ms. CASTOR. Thank you, Mr. Chairman. I think this investigation by the committee is very important on nursing home resident care and the quality of our skilled nursing centers across the country and I appreciate the focus on emergency preparedness. It has not been a year since Hurricane Irma swept through and I think it is important for us to go through what CMS is doing, what States are doing.

One thing that should not be done has become clear here as was reported by the AP earlier this year. As Hurricane Irma bore down on Florida, Governor Rick Scott gave out his cell phone number during a conference call with administrators of the State's nursing homes and assisted living facilities. He told them to contact him if they ran into problems and he would try to get help.

So they did 120 times according to phone records released earlier this year, not last year. Nearly all the calls went directly to voice mail before being returned. The Associated Press reached 29 of the callers and found that in numerous cases the Governor's offer to personally intervene may have slowed efforts to get help and fostered unrealistic and potentially dangerous expectations that Scott could resolve problems.

Irma knocked out power across much of Florida as its strongest winds swept from Key West to Jacksonville, so most of the skilled nursing centers asked for restoration of electricity. But Florida is served by private electric companies and municipal utilities and none are directed by the state, so the Governor's office could only request that particular nursing homes be given priority.

Twelve patients later died of overheating at a nursing home that called Scott's cell phone three times. Its administrators say Scott's staff didn't get them help restoring the air conditioning but we know it was a significant management failure as well by the owners of Hollywood Hills. This cannot be the answer for emergency preparedness.

So I understand now there are new requirements that went into effect in November of 2016. CMS is now surveying states. That began last year. What have we found? Are the states following through? I will let you begin, Doctor.

Dr. GOODRICH. Absolutely. Thank you for the question. As you mentioned, we did finalize the emergency preparedness rule in November of 2016. This applied to all Medicare-certified facilities certainly including long-term care facilities or nursing homes. We began verifying that compliance in November of 2017.

So far we have surveyed about 75 percent of facilities. We anticipate we will have surveyed across the country a hundred percent of facilities by February of 2019. As you noted, there is a need for proper communications systems when there is a disaster and one of the components of the emergency preparedness rule that facilities are now required to adhere to is to develop and maintain communications systems to contact appropriate staff and authorities.

Ms. CASTOR. So are you finding now in the surveys that they are adhering to the new requirements?

Dr. GOODRICH. So we are finding currently that there have been some providers that have been cited for noncompliance so we are working with them to bring them into compliance rapidly. That is an area that they are required to adhere to. Currently, we are not finding that that is one of the most commonly cited deficiencies, but it is something that we are surveying for actively.

Ms. CASTOR. Thank you. States have a critical role here and I am concerned with certain States not following through with requirements. For instance, OIG's audits have found that some States fell short in investigating the most serious complaints in nursing homes.

Ms. Dorrill, what are the nature of these complaints and what should we expect the States to do in response?

Ms. DORRILL. The complaints ran across the board and then half of them were associated with high priority or immediate jeopardy, so serious complaints. And so I think the issue at hand is that states have to be held accountable. Dr. Goodrich talked a bit about that system and I think it's critical to all these pieces coming together that the states are understanding the new requirements and effectively enforcing those in the homes.

Ms. CASTOR. Do you believe CMS is holding states accountable when they do not follow through with their responsibilities?

Ms. DORRILL. So much of this is new, we'll certainly be looking at it. But so much of the new requirement in the guidance is just new within the last 9 months and so we don't know but we certainly have pointed out weaknesses. And we think that it's a two-pronged approach. It's education and it's also ensuring that there's some kind of accountability on the part of the States to ensure that they follow through.

Ms. CASTOR. Thank you. I yield back.

Mr. HARPER. The gentlewoman yields back. The chair will now recognize the gentleman from Virginia, the vice chairman of the subcommittee, for 5 minutes.

Mr. GRIFFITH. Thank you very much, Mr. Chairman. I greatly appreciate it.

Dr. Goodrich, my colleagues, Congresswoman Black, Congressman Adrian Smith, Luján, and Crowley and I recently introduced the Reducing Unnecessary Senior Hospitalization Act of 2018 which seeks to improve quality in nursing homes by providing quality acute care at patients' bedsides via telehealth instead of

transferring them to the hospital. By CMS' own calculations, two-thirds of hospital transfers are avoidable leading to increased costs to Medicare and negatively impacting health outcomes and quality of care.

What are your thoughts on the potential for complementing current nursing home staff with emergency trained first responders utilizing telehealth to connect physician specialists, i.e., emergency physicians that might not otherwise be available to this patient population?

Dr. GOODRICH. So thank you for that question and letting me know about this pending legislation. So we do understand that as you mentioned transfers to the hospital, that's a very disrupting event for a nursing home patient and many of them are avoidable. This is something we actually measure as part of our quality reporting programs so we're certainly aware that there's a significant level of admissions to a hospital.

So we would be very interested and willing to provide technical assistance to you and your staff on this legislation at your convenience.

Mr. GRIFFITH. Well, I appreciate that very much and thank you. I am really excited by telemedicine. Representing a fairly rural district, I can tell you that one of my small nursing home chains has implemented wound care by using telemedicine, so they have a wound care specialist who is available.

And one of their nurses will go in and see the patient who may have a bedsore or some other kind of injury and they are looking at through a pair of glasses that has a camera on it and the wound specialist wherever they are in the United States can see that wound, get a color picture, be able then to tell the nursing home staff what needs to be done to make sure that that wound is being treated properly and taken care of. So I am really excited about telemedicine as a whole.

Let me go to your payroll-based journal for staffing, because I do think that sometimes there may be some confusion. And while we recognize that we want the staffing to be there so you all can use it as a tool, you mentioned it in your statement, Mr. Dicken mentioned in his that the self-reporting hadn't worked because there was a difference.

But I think that may be a little unfair to CMS and to the nursing homes affected, to some of them. Not the bad actors but people that are really trying, because am I not correct that it is a slightly different standard? In self-reporting if you had a salaried employee who worked 50–55 hours a week they got to count that extra time, but under your report which I have no quarrel with, I am just saying they are different, you only count those folks at a maximum of 40 hours of being on the floor.

Likewise, if you have an LPN who is doing supervisory work, they don't get credit for their supervisory time where an RN would. Again no quarrel with the change, but just saying that to say that the old reporting system was intentionally underreporting might not be fair since it is really apples to oranges. Wouldn't you agree with that?

Dr. GOODRICH. The previous reporting system was essentially a 2-week snapshot that the nursing homes completed on a form dur-

ing their recertification survey. The current system as you mentioned is based upon daily staffing levels of numerous different types of staff that the nursing homes have to report quarterly to CMS. And certainly as we were standing that up we had to make certain decisions around ensuring that what is reported is auditable back to the payroll so that it could be as it is required by law so that it could be as accurate as possible.

So the situations you mentioned around a salaried employee, yes, we only count the 40 hours a week that they would be working.

Mr. GRIFFITH. And I don't have any quarrel with that but to say that there was understaffing previously when you are using different metrics wouldn't really be fair to CMS or to some of the nursing homes. Wouldn't that be fair to say?

Dr. GOODRICH. I would say it's very difficult to compare the two.

Mr. GRIFFITH. Difficult to compare, OK.

The Commonwealth of Virginia partnering with healthcare providers developed a long-term care mutual aid plan which is a voluntary agreement among participating nursing homes that they will share supplies, resources, and house residents from other facilities if a serious need arises. We heard Chairman Walden say earlier that one of his nursing homes or a small chain had a facility in California and was looking to move patients to Oregon. This is actually a statewide system.

Are you familiar with this type of plan and do you think it will work and do you think other sStates will adopt it?

Dr. GOODRICH. I am not familiar with this kind of plan but we certainly would be interested to learn more and again our staff would be glad to follow up with you on this.

Mr. GRIFFITH. Very good. Thank you so much.

I yield back, Mr. Chairman.

Mr. HARPER. The gentleman yields back. The chair will now recognize the gentleman from California, Mr. Ruiz, for 5 minutes.

Mr. RUIZ. Thank you, Mr. Chairman. Taking care of seniors has been a big priority for me as a physician. I am an emergency medicine doctor, Dr. Goodrich, and now as a Member of Congress advocating for them here. And when a loved one is placed in the care of a nursing home, we trust and expect that they will receive high quality care and as we know many nursing homes do exactly that. But it is also clear from years of reports from OIG and GAO that there are problematic providers out there.

Ms. Dorrill, your office did groundbreaking work that identified instances of adverse events in nursing homes and you found that one in three Medicare beneficiaries experienced harm during their stay. So what kind of adverse events did these residents experience, can you elaborate on those?

Ms. DORRILL. Yes, thank you for the question. It really ranged the gamut. And that's actually a part of our message is that we found that nursing homes were focusing on just a small number of events, falls with injury, for example, and pressure ulcers, and they were excluding a broad range of events that were already happening that went unnoticed as harm. Things like blood clots and dehydration that can seem like subtle—

Mr. RUIZ. That they didn't identify and allowed it to persist for a time. How about medical errors, giving the wrong medication, et cetera?

Ms. DORRILL. Fourteen percent of our events involve medical error. When a lot of people think about adverse events they think it's all medical error. But one of the things that we've tried to promulgate is this notion that adverse events can occur from general substandard care. It's not really a mistake, it's just not doing the right thing.

Mr. RUIZ. So you say that half of these were preventable. Can you give me some examples of those that were not preventable that—

Ms. DORRILL. Yes. So, for example, if someone was given a medication and they were allergic to that and had a reaction but no one knew that they were allergic, that was not information that the physician could have acted upon.

Mr. RUIZ. And so are these different adverse events not on the state agencies' survey lists? Why are they not looking for these?

Ms. DORRILL. I think that there's been a revolution and this is true for hospitals too in the whole notion of adverse events. And CMS has changed its hospitals provisions as well that I think there was just a narrow focus on a small number of events and people weren't thinking about harm more broadly.

Mr. RUIZ. So they weren't.

Ms. DORRILL. No.

Mr. RUIZ. They weren't looking for these different types of adverse events.

Ms. DORRILL. That's correct.

Mr. RUIZ. So I would like to turn to another quality of care concern. In your recent reporting, OIG again identified Medicare beneficiaries in nursing homes who suffered harm, this time from abuse and neglect, where still OIG found that, quote, a significant percentage of these incidents may not have been reported to law enforcement.

So I find this very troubling and so did you, or OIG, enough to issue an early alert to CMS about the findings. What are some of the immediate actions CMS can take to address these vulnerabilities?

Ms. DORRILL. Thank you. We first requested that they do what we did which is it's possible to look in the claims and find out a lot of these things are claims associated with abuse and neglect and that we suggested that CMS do that to monitor the situation. And then, secondly, we also suggested that they enhance their pursuit of the authority to be able to give remedies when these events were not reported.

Mr. RUIZ. Dr. Goodrich, what has the agency taken, what actions has the agency taken to address this finding?

Dr. GOODRICH. So regarding the recommendation to look in the claims for emergency room services and matching those claims to skilled nursing facilities, that is something that we are currently exploring the feasibility of doing.

Mr. RUIZ. You haven't started it but you are just looking into it.

Dr. GOODRICH. We're exploring whether or not that's feasible to do to be able to have that information to the surveyors.

Mr. RUIZ. Well, by law, as an emergency physician if somebody reports any suspicion of abuse or neglect that has to go into the medical record and that has to be reported to the county officials and APS and all that so that would be a good place to start.

I have another question in terms of empowering the clients and consumers and also their families. Is there any requirement that when a patient gets or a person gets admitted to a nursing home during the orientation that they are given an understanding of their rights, of quality measures, resources, to understand more about what those quality measures are and also a way to report any concerns to a third party like an agency or CMS, is that a requirement, part of your requirements for CMS so that they know that and is that being implemented properly?

Dr. GOODRICH. Yes. So yes, that is a requirement as part of our requirements for participation that residents or their, and their families or their surrogates be informed of their rights as soon as they are admitted into a nursing facility and that they are informed of their rights to file complaints with the state survey agency or with law enforcement.

Mr. RUIZ. Are they given the information on how to do that?

Dr. GOODRICH. Yes, it's supposed to be posted in the nursing home. Sorry, I'm not familiar with the details.

Mr. RUIZ. Yes, see, that is the difference that Ms. Dorrill was saying. It is either posted or you have something in writing, but the true understanding and the implementation of that information is a different story.

So do we know if it is being conducted in a way where during the orientation they are being explained on how to file a complaint?

Dr. GOODRICH. Yes. As part of the admission process in addition to everything about the plan of care in clinical care, one of our conditions or requirements for participation is around patient rights and being informed of those rights.

Mr. RUIZ. Thank you.

Mr. HARPER. The gentleman yields back. The chair will now recognize the gentlewoman from Indiana, Mrs. Brooks, for 5 minutes.

Mrs. BROOKS. Thank you, Mr. Chairman, and thank you for holding this very important hearing.

Ms. Dorrill, I would like, as Chairman Harper talked about in his opening statement, I want to focus a little bit on my line of questioning regarding the owner of the facility where the 12 residents died in the aftermath of Hurricane Irma, the Hollywood Hills. Because it is my understanding that Dr. Michel had been the subject of wrongdoing in the past, including settling with the Department of Justice long ago, corporate integrity agreement, after being implicated in a scheme to receive kickbacks for providing unnecessary medical treatment to elderly residents, and that was the '06 timeframe.

Can you please explain—and I am a former U.S. Attorney so I have worked with HHS OIG. Can you explain what tools are available to you to exclude facility owners from owning nursing homes if obviously OIG had determined and there was a settlement and so forth, but they were involved in participating in this unlawful conduct or fraud, can you go into deeper detail about exclusion process?

Ms. DORRILL. Yes, just to say though, I'm not in the Counsel's Office. I'm not an investigator but I'll do my best, that OIG has a number of tools at our disposal and this it's critical to us. It's the main part of our work that we hold wrongdoers accountable. And so I think the important thing to remember is that those tools are at our disposal and that it depends on the specific facts and circumstances of the case what direction we go.

But we certainly have the exclusion authority. We also have tools such as under the False Claims Act we have the ability to impose civil monetary penalties. We also have hundreds of criminal investigators who help their law enforcement partners to investigate criminal cases. So it's a broad range of activity and core to our mission.

Mrs. BROOKS. Can you talk a little bit though about the exclusion authority tool and how long the process takes, who ultimately makes the decision as to when a provider is on the exclusion list?

Ms. DORRILL. So for those who may not be familiar, and again I'm not in the Counsel's Office, but the OIG can exclude individuals and entities from Federal programs such as Medicare and Medicaid for various types of conduct set forth in statute, including false claims. The primary effect of that exclusion is it will no longer pay for services and we maintain a database with all that information publicly.

OIG has certainly excluded nursing home providers. We recently excluded a 13-facility nursing home chain. We have something like 70,000 excluded providers now, something like 1,600 just this fiscal year alone. So I don't know if that fully answers your question.

Mrs. BROOKS. It doesn't require though a criminal conviction then for a person to be excluded or an entity to be excluded?

Ms. DORRILL. I'll need to take that question, I'd be so happy to, back to my Counsel's Office to make sure that I can give you accurate information there.

Mrs. BROOKS. I think we would like to know more information about the exclusion process from Counsel's Office and from your office particularly relative to, not only we had that incident, but as I understand there are other incidents involving this particular provider let alone the Hollywood Hills incident. So I am interested in knowing how long the process takes, who makes the final decisions, what are the categories that a person can be excluded.

Then I would like to ask both you and Dr. Goodrich a little bit more about the emergency preparedness issues. We are reauthorizing what is called PAHPA, Pandemic All-Hazards Preparedness Act, and we are including in that a provision to have the National Academy of Medicine do an overview of emergency preparedness by hospitals but also long-term care facilities. And because as I am hearing you both say that while there might be plans in place that doesn't necessarily mean the execution of those plans happen.

And do you believe there needs to be more attention to this emergency preparedness that we are not doing enough? Dr. Goodrich?

Dr. GOODRICH. Thank you. Obviously this is a huge priority for us especially given the events of last year. So as we've mentioned we are in the process, in the early process of implementing that regulation and surveying facilities for that. So as you're working, doing your work on this area we'd be more than happy to give you

technical assistance and talk through these issues with you. But we are early in the process and I think learning how it is going.

Mrs. BROOKS. OK, thank you.

Ms. Dorrill, anything further before my time is expired?

Ms. DORRILL. No, just asserting that we found significant problems with the emergency planning and appreciate your focus on that area.

Mrs. BROOKS. Thank you. I yield back.

Mr. HARPER. The gentlewoman yields back. The chair will now recognize the gentlewoman from Illinois, Ms. Schakowsky, for 5 minutes.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman.

If I sound a little impatient about this focus on nursing home and safety it is because I have been working on this issue since the mid-80s, including when I was in the state legislature in Illinois and ever since I have been here in Congress. There are some provisions in the Affordable Care Act that deal with nursing homes that I was successful in getting into the legislation. But I don't know how many GAO reports there have been. I don't know how many reports from oversight committees there have been about these persistent problems.

And as we enter into this age where more, the aging of America, the graying of America, more and more people needing long-term care including nursing homes, it is hard for me to hear words like, this is an important first step. I mean we need to be making last steps now. We need to be getting at the heart of the problem.

Let me ask you, Dr. Goodrich, who has the primary responsibility to make sure that nursing home quality standards are met, States or CMS? And is it the policy of the Trump administration to shift more of the responsibility to the States?

Dr. GOODRICH. So it is a shared responsibility between the States and CMS. We promulgate the regulations and then we oversee the state survey agencies in their implementation of the surveys of the nursing homes and the implementation of those regulations. And as I—

Ms. SCHAKOWSKY. Are we seeing more of a shift toward States or is this always standard?

Dr. GOODRICH. Our process for overseeing health and safety for nursing homes remains the same. It hasn't changed. It remains a partnership in the way that I just described.

Ms. SCHAKOWSKY. What was the rationale behind no longer imposing financial penalties for each day of a violation? Couldn't that be seen as a weakening of a commitment to enforcement?

Dr. GOODRICH. Specifically related to the civil monetary penalties what we were seeing over the last few years and what had been, I think, also recognized by others was that there was quite a bit of variation in how civil monetary penalties were being applied across the country. In some areas not being applied enough when they should have been and in other areas being applied in situations when actually should have had different enforcement remedies applied.

So we sought to make that process more standardized and more uniform so that there was consistency across the country in the correct application of civil monetary penalties. And so last year

what we did was we worked with the regional offices and we developed a civil monetary penalty tool so that survey agencies and our regional offices could go and use that tool which has essentially an algorithm in it to ensure that regions are consistently and accurately applying civil monetary penalties.

Ms. SCHAKOWSKY. Except that I am asking about the penalties then, not the monitoring, the penalties, no longer imposing financial penalties for each day.

Dr. GOODRICH. So we do still impose financial penalties for each day, so per day penalties depending upon the circumstance. And the number of those penalties has actually risen over the last 4 years. In 2014 we had just over 1,100 per day civil monetary penalties and in 2017 we had almost 2,000 per day.

Ms. SCHAKOWSKY. So let me ask you this. Do the nursing home advocates support these changes?

Dr. GOODRICH. We have certainly worked with and been transparent about our intents here related to—

Ms. SCHAKOWSKY. That is kind of a yes or no.

Dr. GOODRICH. I would have to ask the nursing home advocates. We certainly have had discussions with them about this. We have seen—

Ms. SCHAKOWSKY. My understanding is no. Let me also, I want to get to a Human Rights Watch report* found that in an average week nursing facilities in the United States administer powerful anti-psychotropic drugs in over 179,000 people who don't need them. I ask unanimous consent to enter that report into the record.

Mr. HARPER. Without objection.

[The information appears at the conclusion of the hearing.]

Ms. SCHAKOWSKY. These drugs are often given without informed consent. This is after a 2011 OIG report that found rampant overuse of these anti-psychotic drugs.

So, Dr. Goodrich, what actions are CMS taking to address the high rate of these drugs and used 7 years after that OIG report?

Dr. GOODRICH. So we would completely agree that this has been a very significant quality and safety issue within nursing homes. That is why in 2011 in partnership with a number of stakeholders we launched the National Partnership to Improve Dementia Care in Nursing Homes, which was a holistic effort around dementia care, but definitely had a very serious focus around reducing inappropriate use of anti-psychotics in nursing homes.

We have seen over that time period from 2011 to early 2017 a 34 percent reduction in the inappropriate use of anti-psychotics and we are now focusing—

Ms. SCHAKOWSKY. So two-thirds still remains.

Dr. GOODRICH. So there is still overuse. That is true. And there are particular nursing homes in the country who have not made the kinds of improvements that we would hope. And so we have set a new goal to focus on those facilities that are still overusing to unacceptable extent.

Ms. SCHAKOWSKY. Thank you.

*The information has been retained in committee files and can be found at: <https://docs.house.gov/meetings/IF/IF02/20180906/108648/HHRG-115-IF02-20180906-SD003.pdf>.

Mr. HARPER. The gentlewoman yields back. The chair will now recognize the gentlewoman from California, Mrs. Walters, for 5 minutes.

Mrs. WALTERS. Thank you, Mr. Chairman. Federal regulations enumerate a limited number of circumstances under which a nursing facility or skilled nursing facility may transfer or discharge a resident against their will. Under Federal law, a nursing facility or skilled nursing facility must also readmit residents who may temporarily leave for a hospitalization. However, claims that nursing home residents are being dumped or denied readmission appears to be a growing concern.

For example, according to press reports, the California State Long-term Care Ombudsman received more than 1,500 complaints in 2016 alleging that residents have been improperly discharged or evicted from nursing homes in California. This is a 73 percent increase from the number of complaints received since 2011. The Illinois State Ombudsman has stated that such complaints have more than doubled since 2011.

Dr. Goodrich, does CMS view involuntary discharges of nursing home residents or denials of readmission as a significant problem?

Dr. GOODRICH. Yes. This is something that we have also heard reports about happening and it is something that we're concerned about absolutely.

Mrs. WALTERS. When nursing home residents are involuntarily discharged from or denied readmission to a nursing home after a hospital stay, where do they typically end up and how are they cared for?

Dr. GOODRICH. So I think that's variable and that is something that we are trying to explore a little further to understand what's happening on the ground with these residents. So certainly where they end up if that's your question can be quite variable. It can be, with a family member and another facility is often where they will end up going as well.

Mrs. WALTERS. Are you guys trying to do any sort of analysis on this to find out exactly where they are ending up?

Dr. GOODRICH. I'd be happy to get back to you with the answer to the question to how we're taking a look at that. I'm not sure of the specifics.

Mrs. WALTERS. Did you want to add something?

Ms. DORRILL. We have, we're currently underway on this exact issue. I share your concern and we have a study that will be coming out shortly that will be of interest to you.

Mrs. WALTERS. OK, thank you.

Federal law also requires States provide nursing home residents, who allege they were improperly discharged or transferred, with a hearing and, if appropriate, provide for residents a readmission to the nursing home if they prevail. However, it has been alleged that California is failing to enforce its own hearing decisions in instances where decisions have been rendered in favor of residents.

In a 2012 letter to the California Department of Public Health, Center for Healthcare Quality, CMS stated that while it could not advise California what particular state agency should enforce the hearing decisions, as that is for the States to decide, CMS regulations are clear that the state agency must promptly make correc-

tive actions. CMS reiterated California's obligation to enforce its hearing decisions in a letter sent on August 31st, 2017.

Dr. Goodrich, how does CMS verify that States are fulfilling their legal obligations to adjudicate and enforce hearing decisions related to improper nurse home discharges or transfers?

Dr. GOODRICH. So this is a topic with which I'm not terribly familiar of the specifics of the California case, but we'd be very happy to take a look at it and get back to you with responses to that.

Mrs. WALTERS. OK, so then I don't know if you can answer these two questions but I will ask you. Does CMS know whether California is meeting its legal obligations to enforce these decisions?

Dr. GOODRICH. I'm not personally aware but we will get back to you with that.

Mrs. WALTERS. OK, then I have one more. Does CMS know of or have reason to believe other States may be failing to enforce their hearing decisions?

Dr. GOODRICH. I think that's something we certainly would be concerned about and would be happy to get back to you with responses.

Mrs. WALTERS. OK, if you guys could follow up——

Dr. GOODRICH. We will.

Mrs. WALTERS [continuing]. And get back to the committee on that we would really appreciate it.

Dr. GOODRICH. Of course.

Mrs. WALTERS. Thank you and I yield back the balance of my time.

Mr. HARPER. The gentlewoman yields back. I will now recognize the vice chairman of the subcommittee, Mr. Griffith, for the purposes of a follow-up question.

Mr. GRIFFITH. Yes, and I think that Ms. Schakowsky and I might be on the same side, we might not be, but it deals with the daily fines and so forth. Because I am aware of a situation, so I am glad you are looking at it so we can get these algorithms where they make sense because you want to punish people for bad acts.

But I am aware of a situation where coffee was spilled. There was an incident. Something should have been said but somehow the fine ended up being between \$1 million and \$2 million dollars. The patient never went to the hospital. No serious injuries. Clearly something needed to be done, but it seemed that maybe the old algorithm was a little out of whack if you end up with a \$1 million to \$2 million dollar penalty for spilled coffee and no hospitalization.

Dr. GOODRICH. So I'm not familiar with that particular incident, but I think that is potentially an example where there was again as I mentioned before we weren't always seeing consistent application of the civil monetary penalties in both directions. And so that's why we really have been trying to standardize that.

Mr. GRIFFITH. And I appreciate that and hope that you all get that all worked out, but agree that there ought to be penalties and there ought to be something that the nursing homes can know that this is what we are supposed to do, and if there is a problem the penalty will be something that is equal to or in the vein of what ought to be happening.

Thank you, yield back.

Mr. HARPER. The chair will now recognize Ms. Schakowsky for the purposes of a follow-up question.

Ms. SCHAKOWSKY. So in terms of CMS enforcement I wondered how you are using these new—we have been talking somewhat about the payroll staffing data reported by nursing homes to enforce the requirements that each facility have a registered nurse on duty at least 8 hours every day. Let me just state my preference. I think most people who put a person in a nursing home would be shocked that there is not a nurse, a registered nurse 24/7, when they get the bill for the month that there is not a nurse there.

I have a piece of legislation I have introduced, Put a Nurse in a Nursing Home. But I am just wondering how you are following up on that.

Dr. GOODRICH. Absolutely. Thank you for bringing that up. We would agree that the new payroll-based journal system gives us really unprecedented insight into staffing within nursing homes. And as you mentioned, some of the things that we have discovered since we started requiring the reporting of those data is exactly what you mentioned, is that there are some nursing homes that do not have a registered nurse as required by our regulations for 8 hours a day, 7 days a week.

And I think even more concerning is that we see fluctuations in some nursing homes, again a minority but it's there, where that those deficiencies in nurse staffing are more common on the weekends than they are on the weekdays. And I can't think of any clinical reason why that should be different on a Saturday than on a Tuesday.

So that is something that we are concerned about and right now we're taking two actions related to that. I will caveat that by saying this is early, we're exploring the data and we're thinking ahead about other ways in which we can use these data better. So number one, one thing we have already done is in the five-star rating system nursing homes that do not have nurse staffing as appropriate for at least 7 days out of a quarter, their star rating goes down to one star and that affects the staffing star rating and that affects that overall star rating as well.

We are also looking at ways in which we could incorporate the findings that I just mentioned about the fluctuations and the lack of nursing as required by regulation further into the star rating system. The second thing that we're doing is we are embedding the data, the staffing data into our survey software which will then allow the state surveyors when they go onsite to do their investigations to have that information around staffing for that nursing home that they are in so that they can look for quality issues that may be related to staffing based upon the data they have right there in their hand.

So those are two ways in which we're, for now, initially using these data, but we'll continue to explore other ways.

Ms. SCHAKOWSKY. OK, and any of the other two witnesses want to say anything on this topic? I don't know.

Ms. DORRILL. I just wanted to say that we have work underway now on the payroll-based journal and we plan to look at the accuracy of the data and CMS' use of it at this early implementation.

Ms. SCHAKOWSKY. OK. I would really like to see that after you complete your investigation of that issue. So good, thank you very much. I yield back.

Mr. HARPER. The chair will now recognize the gentleman, in celebration of his birthday, the gentleman from Georgia, Mr. Carter.

Mr. CARTER. Thank you, Mr. Chairman. I appreciate you sharing that with everyone. And I do appreciate it very much.

Mr. HARPER. We didn't ask what year.

Mr. CARTER. You can't thank me for that as well, yes.

Well, thank all of you for being here. Full disclosure, I am currently the only pharmacist serving in Congress. Not only am I a pharmacist, but I was also a consultant pharmacist and my expertise and my career was spent in institutional pharmacy in nursing homes. I have gone through Federal inspections, state inspections, so this is something that I am very familiar with.

And I have to tell you I was blessed to be in a number of good nursing homes that provided quality care that really cared about the patients and sometimes I could be frustrated by some of the regulations. And I just want to encourage you, a couple of things. First of all, you know, it is important and it is important to have a registered nurse 8 hours a day. It is important to make sure that rules and regulations are followed, but sometimes we get caught up in the cookie cutter approach that one size fits all.

And I just want to encourage you and I say that because I have seen it firsthand. I have seen how nursing homes struggle and they struggle to find good quality help. They don't pay very high, they can't afford to. It is difficult at times. That is no excuse, you still have to have quality care and as I say I was very blessed to be in facilities that provided quality care.

I think that you have—I am sorry I had another hearing, but we have already talked about the payroll-based journal and about the fact that salaried employees, and trust me, I have seen a salaried, a DNS who has is registered as 40 hours seeing a more 60 or 80 hours a week. So that is kind of a misnomer and I hope you take that into consideration.

And then whenever you are talking about a 30-minute lunch break, I have seen them take 5 minutes to cram something in their mouth and go on and continue on. I have also seen it as you well know, and I know I am the preacher preaching to the choir here, but nursing homes can fall apart quickly. I have been in a nursing home in the morning and it was in top shape and then by the afternoon and just because of the patient population it can really fall apart very quickly.

But anyway, having said that I will tell you that I am concerned particularly the Federal inspectors as it relates to the state inspectors. I have seen the state inspectors sometimes try to do too much because the Federal inspectors are following them. Generally what happens is that you would always know if the fire inspector came and then probably the surveyors, the state surveyors were coming next because the fire inspector would always come first and then the state surveyors would come.

And the Federal surveyors would come after the state surveyors in order to see how well the state surveyors had done and sometimes I felt like they were putting undue pressure on some of the

state inspectors. Not that they didn't need it at times, they did, and it is important. It is important to have the checks and balances in that and I understand that.

I wanted to ask you and I will ask Dr. Goodrich, you, this question about some of the potential complexity for providers that have that the regulations. As I understand it, there has been a temporary moratorium placed on some of the 194 regulations as a result of the stakeholder feedback. Just to clarify, how many of the 194 regulations had this moratorium placed on them?

Dr. GOODRICH. Eight.

Mr. CARTER. Eight of them. And out of those eight did any of those have to do with neglect or with abuse?

Dr. GOODRICH. They did not.

Mr. CARTER. They did not, OK. Good, they should not and I appreciate that. And, finally, do facilities still have to enforce these eight regulations and have a plan in place to fix them if they are noncompliant?

Dr. GOODRICH. Absolutely. That's our expectation, yes.

Mr. CARTER. That is your expectation, good. Again you know, I have seen the burden that can be placed on these facilities and again no one is accepting and I am certainly not advocating that they shouldn't have quality care. This is a very feeble, if you will, population that needs this help. But I just want to make sure we have balance here. I want you to understand that I have worked side by side with these people in the nursing homes and they are good people for the most part.

Now, like every profession you have bad actors and you have to get rid of those bad actors and to a certain extent, to a large extent that is your responsibility and the responsibility of the state surveyors. We need to get those bad actors out. They need to be brought to justice, if you will. But for the most part, I just feel like I need to express to you the true quality work that many of these facilities provide and that many of these employees provide. And, Mr. Chairman, I will yield.

Mr. HARPER. The gentleman yields back. The chair will now recognize the gentleman from Florida, Mr. Billirakis, for 5 minutes.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I appreciate it. Thanks for holding this hearing, so very important.

As you know, Mr. Chairman, last year we had Irma that hit Florida. The many hardworking staff of our nursing homes and assisted living facilities prepared for the hurricane, 862 facilities evacuated, over 2,000 facilities lost power in the state of Florida. They were tested by the storm and the vast majority passed. Again those folks were doing the Lord's work and we do appreciate them so very much.

Yet, in every group there are bad actors as my colleague just said. We had the Rehabilitation Center at Hollywood Hills fail to take the proper measures to protect their residents and as a result 12 people died from heat exposure despite having a hospital across the street from the facility. These deaths were 100 percent preventable.

One of the concerns that have is how many facilities are not in compliance with the emergency rule. Dr. Goodrich, I believe that CMS began compliance surveys last year. That is my under-

standing. Do we know how many facilities are currently not in compliance with the emergency rule? That is my first question.

Dr. GOODRICH. Certainly. So we are about 75 percent of the way through surveying all facilities nationally for the emergency preparedness requirements. We will have completed surveys for a hundred percent of facilities by February of 2019. While we are finding that the majority of facilities are in compliance or come into compliance quickly, we have had some citations for noncompliance that are intended to swiftly bring these facilities into compliance. So we have had about 2,300 facilities or so, so far, be cited for noncompliance that then would have to implement a corrective action plan in order to come into compliance.

Mr. BILIRAKIS. So 2,300 out of how many?

Dr. GOODRICH. There's a total of about 15,600 nursing homes but again they haven't all been surveyed yet.

Mr. BILIRAKIS. Right, so but the majority of them have been surveyed.

Dr. GOODRICH. Seventy five percent about.

Mr. BILIRAKIS. OK, thank you. The rehab center had their provider agreement terminated. This is the one that I was speaking of in Hollywood, Florida. It was terminated by CMS. Despite this, the owner of the rehab center still has an ownership stake in 11 other facilities that participate in the Medicare program. These facilities continue to operate despite the tragedy that occurred last year and the previous allegations that the Department of Justice made against the owner regarding providing unnecessary medical treatment to seniors.

Dr. Goodrich, given your experience at CMS, are you surprised by this that there are so many, he is operating so many other facilities? And yes and is he being monitored? Can you maybe expand on that, please?

Dr. GOODRICH. Certainly. So for any Medicare-certified facility of any type they are required to undergo surveys just like nursing homes do, so whatever type of facility an owner may have an ownership interest in. So they have to undergo periodic recertification surveys in the situation of nursing homes, those are annual. And then there's complaint surveys that can take place if somebody files a quality of care complaint.

So any facility no matter what type that is Medicare-certified would have to undergo these surveys as well.

Mr. BILIRAKIS. OK, can you maybe get back to me on whether these other 12 facilities that this person owns follow the emergency rule? Can you give me that information? I know you can't, more than likely you don't have it with you now.

Dr. GOODRICH. What I do know is that the other facilities owned by this owner have undergone the standard recertification surveys. As it relates specifically to emergency preparedness we will have to get back to you on that.

Mr. BILIRAKIS. Please get back to me on that. I appreciate it. Again, Doctor, I know the State is trying to pull the rehab center's owners licenses, but I am told it is tied up in the court system at the moment. I know I don't have a lot of time, so can CMS terminate the provider agreements with the various facilities that he has an ownership stake in? Do you have the ability to do that?

Dr. GOODRICH. As I understand it, Medicare has the ability to bar an individual from owning other facilities under two circumstances. One is if they have a felony conviction and the second is if they're on the OIG exclusion list.

Mr. BILIRAKIS. OK, very good.

Well, thank you, Mr. Chairman. Thanks for allowing me to sit in and thanks for holding this hearing. I appreciate it.

Mr. HARPER. The gentleman yields back.

Just a little quick follow-up to you, Ms. Dorrill, and to you, Mr. Dicken. Both HHS OIG and GAO have found situations where these allegations of abuse or neglect or substandard care they have been reported but state survey agencies failed to investigate those claims in a timely manner. CMS reserves immediate jeopardy classifications for situations that have caused or are likely to cause a serious injury, harm, or death to a resident and require such a claim to be investigated within 2 days.

So, Ms. Dorrill and Mr. Dicken, when state survey agencies fail to conduct those timely investigations especially in cases of immediate jeopardy, does that place nursing home residents at greater risk?

Mr. DICKEN. Certainly as we've looked at the complaint investigation processes we've seen that States have sometimes been challenged to meet timeframes better at the immediate jeopardy types of issues that you raise. We did see, however, that as States are not timely it's much more difficult for States to be able to substantiate allegations and there are higher substantiation when they are meeting timely frameworks. So it is important to have a timely and complete complaint investigation.

Mr. HARPER. All right. Well, let me follow up on that. So does this failure also potentially allow facilities which may have in fact harmed a resident to go unpunished and perhaps give a false impression that they are providing a better standard of care than they actually are?

Mr. DICKEN. Well, certainly to the extent that the complaints are not investigated or not investigated in a timely manner that as you know can make it hard to substantiate. Certainly there are other processes that can go in and identify that as part of the standard survey process, but that is a real concern that if they are not being substantiated and because of not timely reviews.

Mr. HARPER. Thank you.

Ms. Dorrill, anything you would like to add to that?

Ms. DORRILL. Just to reiterate how important timeliness is in terms of substantiation. We did find that there were only a handful of States who had substantial problems with that to the extent that that's helpful.

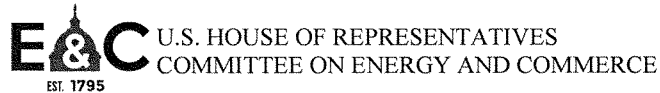
Mr. HARPER. I want to thank each of you for being here. Our concern is the care and well-being of the residents of any of these facilities. They are the loved ones of many families that care greatly about what happens. You have a great responsibility. We thank you for being here today.

I also want to remind members that they have 10 business days to submit questions for the record, and should you receive any of those as witnesses from today we would appreciate your response

as promptly as possible to that. With that the subcommittee is adjourned.

[Whereupon, at 12:00 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]



September 4, 2018

TO: Members, Subcommittee on Oversight and Investigations

FROM: Committee Majority Staff

RE: Hearing entitled “Examining Federal Efforts to Ensure Quality of Care and Resident Safety in Nursing Homes.”

The Subcommittee on Oversight and Investigations will hold a hearing on Thursday, September 6, 2018, at 10:15 a.m. in 2322 Rayburn House Office Building, entitled “Examining Federal Efforts to Ensure Quality of Care and Resident Safety in Nursing Homes.” The purpose of the hearing is to explore the roles of the Centers for Medicare and Medicaid Services (CMS) and the Office of Inspector General at the U.S. Department of Health and Human Services (HHS) relating to the management and safety of nursing home facilities.

I. WITNESSES

- Kate Goodrich, M.D., Director, Center for Clinical Standards and Quality, and Chief Medical Officer, CMS;
- Ruth Ann Dorrill, Regional Inspector General, HHS OIG; and
- John Dicken, Director, Health Care, Government Accountability Office (GAO).

II. BACKGROUND

The Committee on Energy and Commerce (the Committee) began conducting oversight of nursing homes after numerous media reports described instances of abuse, neglect, and substandard care occurring at SNFs and NFs across the country, including the Rehabilitation Center at Hollywood Hills where at least 12 residents died in the immediate aftermath of Hurricane Irma in September 2017.¹

¹ See, e.g., NH Staff, *Nursing home lawyers a no-show in records case*, NAPLES HERALD, May 22, 2018, <http://naplesherald.com/2018/05/22/nursing-home-lawyers-a-no-show-in-records-case/>; Blake Ellis and Melanie Hicken, *Sick, Dying and Raped in America's Nursing Homes*, CNN, Feb. 22, 2017, <http://www.cnn.com/interactive/2017/02/health/nursing-home-sex-abuse-investigation/>.

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A. Management Failure at the Rehabilitation Center at Hollywood Hills

On October 20, 2017, the Committee sent a bipartisan letter requesting documents and information from Jack Michel, an owner of the Rehabilitation Center at Hollywood Hills (Rehabilitation Center) where at least 12 residents died in the immediate aftermath of Hurricane Irma in Florida.² The Committee raised concerns about the organization's failure to protect the health, safety, and welfare of residents at the facility.³ According to the Florida Agency for Health Care Administration (AHCA), the Rehabilitation Center failed to follow adequate emergency management procedures after the facility's air conditioning system lost power during Hurricane Irma.⁴ Despite increasingly excessive heat, staff at the facility did not take advantage of a fully functional hospital across the street and "overwhelmingly delayed calling 911" during a medical emergency.⁵

The facility also had contractual agreements with an assisted living facility and transportation company for emergency evacuation purposes yet did not activate these services.⁶ CMS ultimately terminated the Rehabilitation Center from the Medicare and Medicaid programs following an on-site inspection where surveyors found that the facility failed to meet Medicare's basic health and safety requirements.⁷ During a hearing before the Subcommittee on Oversight and Investigations in October 2017, CMS described the events at this nursing home as a "complete management failure."⁸

On November 17, 2017, Dr. Michel provided a response through his attorney to the Committee's inquiry, contending among other things, that the facility made patients as

² Letter from Hon. Greg Walden, Chairman, H. Comm. on Energy & Commerce, et al., to Dr. Jack Michel, Owner, Rehabilitation Center at Hollywood Hills, LLC (Oct. 20, 2017), available at <https://energycommerce.house.gov/wp-content/uploads/2017/10/20171020HollywoodHills.pdf>; See also NH Staff, *supra* note 1.

³ Letter from Hon. Greg Walden, Chairman, H. Comm. on Energy & Commerce, et al., to Dr. Jack Michel, Owner, Rehabilitation Center at Hollywood Hills, LLC (Oct. 20, 2017).

⁴ Florida Agency for Health Care Administration, *Press Release: AHCA Suspends the License of the Rehabilitation Center of Hollywood Hills* (Sept. 20, 2017); Paul McMahon, et al., *Ninth nursing home patient dies; Gov. Scott details contact with state*, SUN SENTINEL, Sept. 19, 2018, <http://www.sun-sentinel.com/news/hollywood-nursing-home-hurricane-deaths/fl-reg-nursing-home-ninth-death-20170919-story.html>.

⁵ AHCA Press Release, *ACHA Suspends the License of the Rehabilitation Center of Hollywood Hills*, (Sept. 20, 2017); U.S. Dep't of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), Survey of the Rehabilitation Center at Hollywood Hills, LLC, at 2 (Sept. 22, 2017); *State of Florida, Agency for Health Care Administration vs. Rehabilitation Center at Hollywood Hills, LLC*, Emergency Suspension Order (Sept. 20, 2017).

⁶ U.S. Dep't of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), Survey of the Rehabilitation Center at Hollywood Hills, LLC (Sept. 22, 2017).

⁷ U.S. Dep't of Health and Human Services, Centers for Medicare and Medicaid Services, *Notice to Public of Rehabilitation Center at Hollywood Hills, Termination Notice* (Oct. 11, 2017), available at <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Termination-Notice-Florida-NH-Rehabilitation-Center-at-Hollywood-Hills-LLC.pdf>.

⁸ *Examining HHS's Public Health Preparedness for and Response to the 2017 Hurricane Season: Hearing Before the Subcomm. On Oversight & Investigations of the H. Comm. On Energy and Commerce*, 115th Cong., Preliminary Transcript, 108 (Oct. 24, 2017) available at <https://docs.house.gov/meetings/IF/IF02/20171024/106530/HHRG-115-IF02-Transcript-20171024.pdf>.

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comfortable as possible during the loss of air conditioning.⁹ According to the letter, “although AC power was lost on September 10, Hollywood Hills continued to otherwise have electrical power, and deployed eight ‘spot coolers’ (portable air conditioning units that had been purchased as part of hurricane preparedness) and numerous fans through the building in an effort to keep residents as comfortable as possible, given the loss of central air conditioning.”¹⁰ However, according to an engineer testifying in the ongoing litigation between the Rehabilitation Center and the State of Florida, Hollywood Hills failed to properly ventilate the portable coolers which resulted in increased temperatures in most of the facility, particularly the second floor where the majority of deaths occurred.¹¹ According to the expert, the coolers operated by the facility “made it worse.”¹²

i. Past Allegations Involving Dr. Michel and Corporate Integrity Agreement

The Committee’s investigation and public reports revealed that facilities affiliated with Dr. Michel have been the subject of federal government scrutiny for over a decade. In 2006, Larkin Community Hospital (Larkin), and others entered into a settlement agreement with the Department of Justice (DOJ) to resolve a civil case in which the government alleged Dr. Michel and his associates paid kickbacks and performed medically unnecessary treatments on elderly beneficiaries to generate Medicare and Medicaid payments.¹³ According to DOJ’s complaint, Dr. Michel initiated the scheme during a meeting with an associate of the then-owner of a nearby hospital, Larkin by proposing, “ask your boss if he would pay \$1 million to make \$5 million.”¹⁴ Thereafter, Dr. Michel and his associates allegedly entered into a scheme to engage in seven different types of kickback arrangements.¹⁵

Dr. Michel and the parties eventually settled with DOJ for \$15.4 million without an admission of guilt.¹⁶ With the settlement, Larkin and Dr. Michel entered into a five-year

⁹ Letter from Geoffrey D. Smith, Atty., Smith & Associates, to Hon. Greg Walden, Chairman, H. Comm. on Energy & Commerce, et al., (Nov. 17, 2017) (On file with the Committee).

¹⁰ *Id.*

¹¹ Deposition of William Scott Crawford, PE, *State of FL for Healthcare Admin. Vs. Rehabilitation Center at Hollywood Hills*, Feb. 16, 2018, available at; see also Terry Spencer, *Expert: Coolers Made it Worse in Nursing Home Where 12 Died*, ASSOCIATED PRESS, Mar. 23, 2018, <https://www.yahoo.com/news/expert-coolers-made-worse-nursing-home-where-12-185954138.html>; Erika Pesantes, et. al, *Second Floor was Deadliest at Nursing Home with No Air Conditioning*, SUN SENTINEL, Oct. 6, 2017, <http://www.sun-sentinel.com/news/hollywood-nursing-home-hurricane-deaths/fl-sb-nursing-home-sunrise-hollywood-20170927-story.html>.

¹² *Id.*

¹³ U.S. Dep’t of Justice, Press Release, *Miami Hospital Pays \$15.4 Million to Resolve Fraud Case for Kickbacks & Medically Unnecessary Treatments* (Nov. 30, 2006), available at https://www.justice.gov/archive/opa/pr/2006/November/06_civ_803.html.

¹⁴ *United States v. Jack Jacob Michel, et al.*, Complaint of the United States, No-04-21579-CIV-JORDAN/TORRES, at 31 (Filed Jun. 29, 2004) (S.D. Fla.).

¹⁵ *Id.* at 30-36.

¹⁶ U.S. Dep’t of Justice, Press Release, *Miami Hospital Pays \$15.4 Million to Resolve Fraud Case for Kickbacks & Medically Unnecessary Treatments* (Nov. 30, 2006) available at https://www.justice.gov/archive/opa/pr/2006/November/06_civ_803.html; See also *United States v. Philip Esformes*, Government’s Motion for Pre-Trial Detention and Supporting Memorandum, Case No. 16-20549, at Attachment B, Page 6 (Filed Jul. 22, 2016) (S.D. Fla.) (Attachment B includes Settlement Agreement Binder from *United States v. Michel* (“Civil Action”), No-04-21579-CIV-JORDAN/TORRES (S.D. Fla.)).

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Corporate Integrity Agreement (CIA) with HHS OIG in 2006.¹⁷ Despite the CIA, media reports indicate that from approximately 2002 to 2016, at least one then-employee and physicians at Larkin were allegedly involved in the largest single criminal health care fraud case ever brought against individuals by DOJ.¹⁸

ii. Dr. Michel Continues to Own Multiple Health Care Related Facilities Participating in Federal Programs

Last year, state regulators in Florida raised concerns about patient safety at another facility owned by Dr. Michel.¹⁹ In December 2016, the AHCA found 30 violations at Floridian Gardens Assisted Living Facility, including “sexual assault of patients, low staffing, and ignoring patients.”²⁰ As a result, the facility was banned from accepting new patients for several months.²¹ In September 2017, the AHCA took additional steps to close Floridian Gardens.²² According to information obtained by the Committee from CMS, Dr. Michel currently has an ownership interest in at least 11 health care related facilities enrolled in Medicare despite the tragedy at the Rehabilitation Center and other previous instances of apparent wrongdoing.²³

B. Emergency Preparedness at SNFs and NFs

Emergency preparedness is a critical issue for long-term care facilities, and CMS requires that Medicare- and Medicaid-certified nursing homes comply with certain federal requirements regarding emergency preparedness. HHS OIG has examined some of these requirements, issuing reports in 2006 and 2012 regarding emergency preparedness and response in nursing homes.²⁴ In these reports, HHS OIG found that there were gaps in nursing home preparedness and

¹⁷ U.S. Dep’t of Health and Human Services, Office of Inspector General, Integrity Agreement Between the Office of Inspector General of the Dep’t of Health and Human Services and Jack J. Michel, M.D. (Nov. 17, 2006); U.S. Dep’t of Health and Human Services, Office of Inspector General, Integrity Agreement Between the Office of Inspector General of the Dep’t of Health and Human Services and Larkin Community Hospital (Nov. 13, 2006).

¹⁸ Jay Weaver, *Bribes to low-paid state worker key to \$1 billion Miami Medicare fraud case, prosecutors say*, MIAMI HERALD, Jul. 29, 2017, <http://www.miamiherald.com/news/local/article164232522.html>; See also U.S. Dep’t of Justice, Press Release, *Three Individuals Charged in \$1 Billion Medicare Fraud and Money Laundering Scheme* (Jul. 22, 2016), available at <https://www.justice.gov/opa/pr/three-individuals-charged-1-billion-medicare-fraud-and-money-laundering-scheme>.

¹⁹ Melanie Payne & Arek Sarkissian, *Nursing Home Deaths: Owner’s Other Facility Faced State Ban on New Patients*, USA TODAY NETWORK FLORIDA, Sept. 15, 2017, <https://www.usatoday.com/story/news/nation-now/2017/09/15/nursing-home-deaths-owners-other-facility-faced-state-ban-new-patients/672340001/>.

²⁰ *Id.*

²¹ *Id.*

²² See Florida Agency for Health Care Administration, Press Release: *AHCA Takes Additional Action to Close Larkin-Owned ALF* (Sept. 28, 2017), https://www.ahca.myflorida.com/Executive/Communications/Press_Releases/pdf/Larkin-OwnedALFPR.pdf.

²³ E-mail from Staff, Centers for Medicare and Medicaid Services to Staff, H. Comm. on Energy & Commerce (May 11, 2018, 5:12 pm) (On file with the Committee).

²⁴ U.S. Dep’t of Health and Human Services, Office of the Inspector General, *Nursing Home Emergency Preparedness and Response During Recent Hurricanes*, OEI-06-06-00020 (Aug. 2006) available at <https://oig.hhs.gov/oei/reports/oei-06-06-00020.pdf>; U.S. Dep’t of Health and Human Services, Office of Inspector General, *Gaps Continue to Exist in Nursing Home Emergency Preparedness and Response During Disasters: 2007-2010*, OEI-06-09-00270 (Apr. 2012) available at <https://oig.hhs.gov/oei/reports/oei-06-09-00270.pdf>.

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response and made recommendations to CMS to update and revise certain federal requirements regarding emergency preparedness.²⁵

Over the past decade, CMS has adopted new policies and procedures to improve emergency preparedness in nursing homes and other health care facilities. For example, in 2007, CMS issued three emergency preparedness checklists for health care facilities (including nursing homes), State Long Term Care (LTC) Ombudsman programs, and State Survey Agencies.²⁶ More recently, in September 2016, CMS finalized a new emergency preparedness rule for Medicare and Medicaid participating providers and suppliers that imposed new requirements on 17 different providers/suppliers, including long-term care facilities.²⁷ The rule, among other things, outlined four core elements of the Emergency Preparedness Program for all provider types (*i.e.*, Risk Assessment and Planning, Policies and Procedures, Communication Plan, and Training and Testing).²⁸ At the Subcommittee's October 2017 hearing entitled "Examining HHS's Public Health Preparedness for and Response to the 2017 Hurricane Season," CMS was asked about its emergency preparedness requirements and testified that the surveyors would begin surveying for the new rule starting in November 2017 and that the rule required, among other things, generators, emergency preparedness plans, and training on a continual basis.²⁹

C. CMS Oversight of National Nursing Homes

On April 2, 2018, the Committee wrote to CMS Administrator Seema Verma, requesting documents and information relating to CMS' oversight of SNFs and NFs participating in the Medicare and Medicaid programs.³⁰ Media reports cited in the letter described instances of nursing home residents being abused and neglected and, in some instances, the nursing homes subsequently failing to detect and investigate adequately the abuse and neglect.³¹ Analysis conducted by one news outlet found that between 2013 and 2016, the federal government cited more than 1,000 nursing homes for either mishandling cases related to, or failing to protect residents against, rape, sexual abuse, or sexual assault, with nearly 100 facilities incurring multiple citations.³² The Centers for Disease Control (CDC) National Center for Health

²⁵ *Id.*

²⁶ U.S. Dep't of Health and Human Services, Office of Inspector General, *Gaps Continue to Exist in Nursing Home Emergency Preparedness and Response During Disasters: 2007-2010*, OEI-06-09-00270, at 5 (Apr. 2012).

²⁷ Centers for Medicare and Medicaid Services, *Emergency Preparedness Rule*, CMS.GOV (last updated Jul. 9, 2018), available at <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Emergency-Prep-Rule.html>.

²⁸ *Id.*

²⁹ The compliance deadline for the new rule was November 15, 2017. *Id.*; *Examining HHS's Public Health Preparedness for and Response to the 2017 Hurricane Season: Hearing Before the Subcomm. on Oversight & Investigations of the H. Comm. on Energy and Commerce*, 115th Cong., Preliminary Transcript, 108 (Oct. 24, 2017) available at <https://docs.house.gov/meetings/IF/IF02/20171024/106530/HHRG-115-IF02-Transcript-20171024.pdf>.

³⁰ Letter from Hon. Greg Walden, Chairman, H. Comm. on Energy & Commerce, et al., to Hon. Seema Verma, Administrator, Centers for Medicare & Medicaid Services (Nov. 17, 2017) available at <https://energycommerce.house.gov/wp-content/uploads/2018/04/20180402CMS.pdf>.

³¹ Ellis and Hicken, *supra* note 1.

³² *Id.*

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Statistics found that, as of 2014, there were 15,600 nursing home facilities in the United States; 69.8 percent of U.S. nursing home facilities have for-profit ownership.³³

For over a decade, HHS OIG has identified improving care for vulnerable populations, including the care provided to individuals receiving nursing home care, as a top management challenge for HHS and has continuously expressed concerns about residents being at risk of abuse and neglect.³⁴ According to HHS OIG's 2017 report on top management challenges:

Nursing facilities continue to experience problems ensuring quality of care and safety for people residing in them. OIG identified instances of substandard care causing preventable adverse events, finding an estimated 22 percent of Medicare beneficiaries had experienced an adverse event during their nursing stay.³⁵

The report further states that "OIG continues to raise concerns about nursing home residents being at risk of abuse and neglect. In some instances, nursing home care is so substandard that providers may have liability under the False Claims Act."³⁶

In addition, GAO has developed a substantial body of work wherein CMS' efforts to ensure that nursing home residents are free from abuse and receive the proper standard of care have been called into question.³⁷

³³ Centers for Disease Control and Prevention, *Nursing Home Care* (last updated May 3, 2017) available at <https://www.cdc.gov/nchs/fastats/nursing-home-care.htm>.

³⁴ U.S. Dep't of Health and Human Services, Office of Inspector General, *Top Management and Performance Challenges Facing HHS 2017, #4 Improving Care for Vulnerable Populations* (last accessed Aug. 29, 2018), <https://oig.hhs.gov/reports-and-publications/top-challenges/2017/2017-tmc.pdf>; U.S. Dep't of Health and Human Services, Office of Inspector General, *Top Management and Performance Challenges Facing HHS 2016, #7 Ensuring Quality of Care and Safety for Vulnerable Populations* (last accessed Aug. 29, 2018), https://oig.hhs.gov/reports-and-publications/top-challenges/2016/TMC_2016_508.pdf; U.S. Dep't of Health and Human Services, Office of Inspector General, *OIG's FY 2015 Top Management and Performance Challenges Facing the Department of Health and Human Services, Management Challenge 6: Ensuring Quality in Nursing Home, Hospice, and Home- and Community-Based Care* (last accessed Aug. 29, 2018), <https://oig.hhs.gov/reports-and-publications/top-challenges/2015/2015-tmc.pdf>.

³⁵ 2017 Management Challenges, *supra* note 34.

³⁶ *Id.*

³⁷ See U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-16-33, *Nursing Home Quality: CMS Should Continue to Improve Data and Oversight* (2015) available at <https://www.gao.gov/assets/680/673480.pdf>. See also U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-11-280, *Nursing Homes: More Reliable Data and Consistent Guidance Would Improve CMS Oversight of State Complaint Investigations* (2011) available at <https://www.gao.gov/assets/320/317514.pdf>; U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-10-197, *Poorly Performing Nursing Homes: Special Focus Facilities Are Often Improving, but CMS's Program Could be Strengthened* (2010) available at <https://www.gao.gov/assets/310/302117.pdf>; U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-10-70, *Nursing Homes: Addressing the Factors Underlying Understatement of Serious Care Problems Requires Sustained CMS and State Commitment* (2009) available at <https://www.gao.gov/assets/300/298953.pdf>; U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-08-517, *Nursing Homes: Federal Monitoring Surveys Demonstrate Continued Understatement of Serious Care Problems and CMS Oversight Weaknesses* (2008) available at <https://www.gao.gov/assets/280/275154.pdf>; and U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-07-241, *Nursing Homes: Efforts to Strengthen Federal Enforcement Have Not Deterred Some Homes for Repeatedly Harming Residents* (2007) available at <https://www.gao.gov/assets/260/258016.pdf>.

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i. Oversight of Nursing Homes: Surveys, Deficiencies, and Corrective Action Plans

HHS utilizes state health agencies or other state agencies to determine if nursing homes meet the minimum federal requirements for participation in the Medicare and Medicaid programs (hereinafter “Conditions of Participation” or “CoPs”).³⁸ Accordingly, through an agreement with HHS, the state agency is required to “conduct standard surveys to determine whether nursing homes are in compliance with Federal participation requirements.”³⁹ A standard survey is defined as “a periodic nursing home inspection,” using procedures specified in CMS’ *State Operations Manual* (hereinafter “Manual”), “that focuses on a sample of residents selected by the state agency to gather information about the quality of resident care furnished to Medicare or Medicaid beneficiaries in a nursing home.”⁴⁰ A survey must take place at each facility “at least once every 15 months.”⁴¹ However, each state must maintain a statewide average of conducting surveys once every 12 months.⁴² Nursing homes that do not achieve substantial compliance within six months will be terminated from participating in Medicare and Medicaid.⁴³

The state is also required to review “complaint allegations” with the option to “conduct a standard survey or an abbreviated standard (complaint survey) to investigate noncompliance with the CoPs.”⁴⁴ “A nursing home’s noncompliance with a Federal participation requirement is defined as a deficiency.”⁴⁵ The state agency determines the deficiency rating utilizing severity and scope components.⁴⁶ Each deficiency is assigned a letter rating of A to L, with L being the most serious and A the least.⁴⁷

Severity is the degree of or potential for resident harm and has four levels, beginning with the most severe: (1) immediate jeopardy to resident health or safety, (2) actual harm that is not immediate jeopardy, (3) no actual harm with potential for more than minimal harm but not immediate jeopardy, and (4) no actual harm with potential for minimal harm. Scope is the number of residents affected or pervasiveness of the deficiency in the nursing home and has three levels: (1) isolated, (2) pattern, (3) widespread. The Manual provides information on the severity and scope of levels used to determine the deficiency rating.⁴⁸

³⁸ See U.S. Dep’t of Health and Human Services, *Office of Inspector General, Kansas Did Not Always Verify Correction of Deficiencies Identified During Surveys of Nursing Homes Participating in Medicare and Medicaid* (A-07-17-03218), Sept. 2017, available at <https://oig.hhs.gov/oas/reports/region7/71703218.pdf>.

³⁹ *Id.*

⁴⁰ *Id.*

⁴¹ *Id.*

⁴² 42 U.S.C. § 1395i-3(g)(2)(A)(iii)(I) and 42 U.S.C. § 1396r (g)(2)(A)(iii)(I).

⁴³ CMS Nursing Home Enforcement, available at <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationEnforcement/Nursing-Home-Enforcement.html>. See also 42 U.S.C. § 1395i-3(h)(2)(C) and 42 U.S.C. § 1396r(h)(3)(D).

⁴⁴ HHS OIG Report, *supra* note 38.

⁴⁵ *Id.*

⁴⁶ *Id.*

⁴⁷ *Id.*

⁴⁸ *Id.*

Table 1: Severity and Scope Levels for Deficiency Ratings⁴⁹

SEVERITY	SCOPE		
	Isolated	Pattern	Widespread
Immediate jeopardy to resident health or safety	J	K	L
Actual harm that is not immediate jeopardy	G	H	I
No actual harm with potential for more than minimal harm but not immediate jeopardy	D	E	F
No actual harm with potential for minimal harm	A	B	C

Nursing homes are required to submit corrective actions plans to either the appropriate state agency or CMS, detailing how the nursing home corrected the deficiency or plans to correct the deficiency.⁵⁰ After receiving the plan, the state or CMS certifies whether the facility is in substantial compliance with the CoPs.⁵¹ Substantial compliance occurs when “there is substantial compliance by verifying correction of the identified deficiencies through obtaining evidence of correction or conducting an onsite review.”⁵²

According to information provided to the Committee by CMS, the number of complaint surveys with deficiencies cited at the immediate jeopardy level has increased each of the last four years. In 2013, there were 1,250 complaints at the immediate jeopardy level compared to 1,801 in 2017, the most recent data available—an increase of more than 44 percent.⁵³

ii. Delays Reviewing Complaint Allegations

While staffing shortages continue to be an issue for a variety of reasons in the nursing home industry and at state agencies, some nursing home residents appear to be placed in unsafe situations because of a lack of oversight by state agencies and CMS.⁵⁴ A September 2017 Data Brief issued by the HHS OIG found that in 2015, 764 immediate jeopardy nursing home complaints were not investigated by state agencies within two working days, as required by CMS, and 473 complaints were not investigated within 15 days.⁵⁵ Immediate jeopardy is described by CMS as being instances where “the facility’s noncompliance with more or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment,

⁴⁹ U.S. Dep’t of Health and Human Services, Office of Inspector General, *Florida Did Not Always Verify Correction of Deficiencies Identified During Surveys of Nursing Homes Participating in Medicare and Medicaid*, A-04-17-0852 (Apr. 2018) available at <https://oig.hhs.gov/oas/reports/region4/41708052.pdf>.

⁵⁰ HHS OIG Report, *supra* note 38.

⁵¹ *Id.*

⁵² *Id.*

⁵³ Centers for Medicare and Medicaid Services, *supra* note 23. Federal law requires states to maintain procedures and adequate staff to investigate complaints of violations of federal requirements by SNFs and NFs. See 42 U.S.C. § 1395i-3(g)(4)(A) and 42 U.S.C. § 1396r(g)(4)(A).

⁵⁴ See John Caniglia & Jo Ellen Corrigan, *Ohio Nursing Home Inspectors Fail to Meet Federal Deadlines Amid Serious Understaffing: A Critical Choice*, THE PLAIN DEALER, Apr 23, 2017, available at https://www.cleveland.com/metro/index.ssf/2017/04/ohio_nursing_home_inspectors_f.html.

⁵⁵ U.S. Dep’t of Health and Human Services, Office of Inspector General, *A Few States Fell Short in Timely Investigation of the Most Serious Nursing Home Complaints: 2011-2015* (OEI-01-16-00330) (Sept. 2017) available at <https://oig.hhs.gov/oei/reports/oei-01-16-00330.pdf>.

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or death to a resident.”⁵⁶ HHS OIG also found that 4,743 high priority nursing home complaints were not investigated in 2015 within the required 10 working day period.⁵⁷

However, it should also be noted that failing to properly address and administer complaint investigations has been a long-standing problem for state agencies and CMS. For example, a report issued by the U.S. General Accounting Office⁵⁸ in 1999 found that “[s]erious complaints alleging that nursing home residents are being harmed can remain uninvestigated for weeks or months. Such delays can prolong situations in which residents may be subject to abuse, neglect resulting in serious care problems like malnutrition and dehydration, preventable accidents, and medication errors.”⁵⁹ According to the report, CMS (then known as the Health Care Financing Administration (HCFA))⁶⁰ had only established minimal standards for complaint investigations and did not perform adequate oversight to ensure resident complaints were being investigated in a timely manner.⁶¹ HHS OIG also made similar findings in a 2006 report, once again noting inadequacies in CMS’ oversight.⁶²

iii. Correction of Deficiencies Not Always Verified

HHS OIG has also issued several reports examining whether states always verified correction of deficiencies identified during surveys of nursing homes participating in Medicare and Medicaid.⁶³ While in some instances HHS OIG found that states properly verified correction of deficiencies identified during surveys of nursing homes,⁶⁴ HHS OIG generally found that states did not always verify correction of deficiencies identified during surveys of nursing homes participating in Medicare and Medicaid.⁶⁵ For example, in September 2017, HHS OIG released a report finding that Kansas did not always verify whether nursing homes corrected

⁵⁶ *Id.*

⁵⁷ *Id.*

⁵⁸ The U.S. General Accounting Office was renamed the U.S. Government Accountability Office (GAO) in July 2004. See GAO Human Capital Reform Act of 2004, Pub. L. 108-271, 118 Stat. 811 (2004).

⁵⁹ U.S. GEN. ACCOUNTING OFFICE, GAO/HEHS-99-80, *Nursing Homes: Complaint Investigation Process Often Inadequate to Protect Residents* (1999) available at <https://www.gao.gov/assets/230/227108.pdf>.

⁶⁰ CNN, *Medicare agency renamed as prelude to reforms*, CNN, June 14, 2001, <http://www.cnn.com/2001/HEALTH/06/14/hcfa.changes/>.

⁶¹ U.S. GEN. ACCOUNTING OFFICE, *supra* note 59.

⁶² U.S. Dep’t of Health and Human Services, Office of Inspector General, *Nursing Home Complaint Investigations* (OEI-01-04-00340) (July 2006) available at <https://oig.hhs.gov/oei/reports/oei-01-04-00340.pdf>.

⁶³ According to a May 2018 report issued by HHS OIG, OIG had released 15 reports related to this topic. See, e.g., U.S. Dep’t of Health and Human Services, Office of Inspector General, *Nebraska Did Not Always Verify Correction of Deficiencies Identified During Surveys of Nursing Homes Participating in Medicare and Medicaid*, A-07-17-03224 (May 2018) available at <https://oig.hhs.gov/oas/reports/region7/71703224.pdf>.

⁶⁴ See, e.g., U.S. Dep’t of Health and Human Services, Office of Inspector General, *Missouri Properly Verified Correction of Deficiencies Identified During Surveys of Nursing Homes*, A-07-16-03217 (Mar. 17, 2017) available at <https://oig.hhs.gov/oas/reports/region7/71603217.pdf>; U.S. Dep’t of Health and Human Services, Office of Inspector General, *Oregon Properly Verified Correction of Deficiencies Identified During Surveys of Nursing Homes Participating in Medicare and Medicaid*, A-09-16-02007 (Mar. 14, 2016) available at <https://oig.hhs.gov/oas/reports/region9/91602007.pdf>.

⁶⁵ HHS OIG Report, *supra* note 63 at Appendix B.

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deficiencies.⁶⁶ The report found that, out of 100 sampled deficiencies identified during CY 2014 surveys, Kansas failed to adequately verify that the deficiencies were corrected 52 percent of the time.⁶⁷ HHS OIG also found that the state failed to conduct required standard surveys within the required 15-month timeframe for 35 of 79 nursing homes in CY 2014.⁶⁸ According to a recent media report, Kansas “may conduct less than 40% of required nursing home surveys” during 2018.⁶⁹

iv. Inconsistency of Penalties

According to information reviewed by the Committee, there appears to be variation in penalties among states and regions relating to how civil monetary penalties (CMPs) are assessed. In some cases, there is little to no correlation between the severity of deficiency and the resulting civil monetary penalty. Even within the same state, some facilities can incur significant civil monetary penalties despite not having any serious deficiencies while other facilities may have been cited for several deficiencies yet incur little to no penalties. For example, at least one nursing home did not incur any financial penalty even after being cited for not protecting residents after a case of sexual abuse was sustained.⁷⁰ There also appears to be a variation relating to intra-facility penalties. For instance, some facilities are cited for having serious deficiencies, sometimes in successive surveys, yet incur little to no monetary penalties. Alternatively, these facilities may incur significant civil monetary penalties for deficiencies that are relatively low on CMS’ severity scale.

v. 1150B Authority Delegation

According to an August 2017 Early Alert, HHS OIG identified 134 Medicare beneficiaries who were treated in 2015 and 2016 for injuries that may have been caused by abuse or neglect when the individual was receiving care at a SNF.⁷¹ HHS OIG raised concerns that CMS has inadequate procedures to ensure that incidents of potential abuse or neglect at SNFs are identified and reported in accordance with applicable requirements.⁷² Under Section 1150B of the Social Security Act, covered individuals in federally funded SNFs and NFs are required to immediately report any reasonable suspicion of a crime committed against a resident of that facility.⁷³ The law imposes various penalties, including CMPs of up to \$300,000 and possible

⁶⁶ U.S. Dep’t of Health and Human Services, Office of Inspector General, *Kansas Did Not Always Verify Correction of Deficiencies Identified During Surveys of Nursing Homes Participating in Medicare and Medicaid*, A-07-17-03218 (Sept. 2017) available at <https://oig.hhs.gov/oas/reports/region7/71703218.pdf>.

⁶⁷ *Id.*

⁶⁸ *Id.*

⁶⁹ Kimberly Marselas, MCKNIGHT’S LONG-TERM CARE NEWS, Apr. 26, 2018, <https://www.mcknights.com/news/agency-may-conduct-less-than-40-of-required-nursing-home-surveys-in-kansas-this-year/article/761192/>.

⁷⁰ Ellis and Hicken, *supra* note 1.

⁷¹ U.S. Dep’t of Health and Human Services, Office of Inspector General, *Early Alert: The Centers for Medicare & Medicaid Services Has Inadequate Procedures to Ensure That Incidents of Potential Abuse or Neglect at Skilled Nursing Facilities Are Identified and Reported in Accordance with Applicable Requirements* (A-01-17-00504) (Aug. 24, 2017) available at <https://oig.hhs.gov/oas/reports/region1/11700504.pdf>.

⁷² *Id.*

⁷³ 42 U.S.C. § 1320b-25(b).

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exclusion from participation in federal health care programs, for failure to report possible crimes against SNF and NF residents.⁷⁴

According to HHS OIG, CMS has not, however, taken any enforcement actions using section 1150B of the Social Security Act or used the penalties it contains despite its effective date of March 23, 2011.⁷⁵ CMS officials told HHS OIG that CMS has not taken any enforcement actions under 1150B “because the HHS Office of the Secretary has not delegated the enforcement of section 1150B to CMS[.]” and that it had “not identified any instances in which a covered individual failed to report an incident of potential abuse or neglect of a Medicare beneficiary.”⁷⁶ CMS further indicated that it had commenced working with the HHS Office of the Secretary in June 2017 to obtain the delegated enforcement authority.⁷⁷ CMS is continuing to work on the delegation authority.

vi. CMS’ Administration of the Special Focus Facility (SFF) Program

As part of the Nursing Home Oversight and Improvement Program, the HCFA⁷⁸ created a Special Focus Facility (SFF) initiative in 1998.⁷⁹ The SFF program is designed to address nursing homes that have more problems than other nursing homes, more serious problems than most other nursing homes, and a pattern of serious problems that has persisted over a long period of time.⁸⁰ A facility is placed in the SFF program if the State Survey Agency selects the facility from a list of program candidates that is created by CMS.⁸¹ As a SFF, the nursing home is subject to twice as many in-person visits by survey teams as other nursing homes and may face progressive enforcement actions.⁸² CMS expects that within about 18-24 months the nursing home will: (1) improve and graduate from the SFF program; (2) be terminated from the Medicare and Medicaid programs; or (3) be provided with an extension of time to continue participating in the SFF program because the nursing home has made “very promising progress.”⁸³

⁷⁴ 42 U.S.C. § 1320b-25(c).

⁷⁵ HHS OIG, *supra* note 71.

⁷⁶ *Id.*

⁷⁷ *Id.*

⁷⁸ The HCFA was renamed the Centers for Medicare & Medicaid Services (CMS) in June 2001. *See* CNN, *supra* note 60.

⁷⁹ *See* Statement of Alice Bonner, PhD, RN, Director of the Division of Nursing Homes, Office of Clinical Standards and Quality, Centers for Medicare & Medicaid Services Before the United States Senate Special Committee on Aging (July 2, 2012), *available at* <https://www.aging.senate.gov/imo/media/doc/hr248ab.pdf>.

⁸⁰ Centers for Medicare and Medicaid Services (CMS), *Special Focus Facility (“SFF”) Initiative* (last updated Aug. 16, 2018), *available at* <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/NHs.html>.

⁸¹ *See* Centers for Medicare and Medicaid Services, *Center for Clinical Standards and Quality/Survey & Certification Group, Fiscal Year (FY) 2017 Special Focus Facility (SFF) Program Update* (Mar. 2, 2017), *available at* <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-20.pdf>.

⁸² Centers for Medicare and Medicaid Services (CMS), *Special Focus Facility (“SFF”) Initiative* (last updated Aug. 16, 2018), *available at* <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/NHs.html>.

⁸³ *Id.*

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Since the program's creation, CMS has made improvements to the program to, among other things, increase the number of nursing homes participating in the program, strengthen enforcement, enhance transparency, and rate all nursing homes using a Five-Star Quality Rating System.⁸⁴ As of August 16, 2018, there were a total of 85 facilities in the SFF program, including 20 newly added facilities to the SFF program, 33 facilities in the SFF program that had not improved, 32 facilities in the SFF program that had shown improvement, and 25 facilities that had recently graduated from the SFF program.⁸⁵ According to CMS' August 16, 2018 update regarding facilities in the SFF program, the amount of time that the current facilities in the SFF program have been in the program ranges from 0 months to 47 months.⁸⁶ Some of these facilities have been in the program longer than CMS' expected 24 months, as the list shows that two facilities have been in the SFF program for more than 24 months and have not improved and 4 facilities have been in the SFF for more than 24 months and have shown improvement.⁸⁷

It is important to note that the SFF program does not supersede the statutory requirement that a nursing home be terminated from the Medicare and/or Medicaid program if it does not achieve substantial compliance with federal requirements within six months of the date of the first findings of noncompliance.⁸⁸

D. Updated SNF and NF Conditions of Participation

Congress enacted the Federal Nursing Home Reform Act (hereinafter "Act" or "Nursing Home Reform Act") as part of the Omnibus Budget Reconciliation Act of 1987.⁸⁹ The enactment of the Nursing Home Reform Act followed the publication of a comprehensive study conducted by the Institute of Medicine's Committee on Nursing Home Regulation which found that, at the time, quality of care in many of the nation's nursing homes was lacking.⁹⁰ The Committee on Nursing Home Regulation therefore recommended "[a] major reorientation of the regulatory system is needed to make it focus on the care being provided to residents and the effects of the care on their well-being."⁹¹

The Act required SNFs and NFs to provide, among other things, "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[.]"⁹² and established minimum personnel requirements

⁸⁴ Centers for Medicare and Medicaid Services (CMS), *Special Focus Facility ("SFF") Initiative* (last updated Aug. 16, 2018), available at <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/NHs.html>.

⁸⁵ *Id.*

⁸⁶ *Id.*

⁸⁷ *Id.*

⁸⁸ See CMS, *supra* note 81. See also 42 U.S.C. § 1395i-3(h)(2)(C) and 42 U.S.C. § 1396r(h)(3)(D).

⁸⁹ Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, 101 Stat. 1330 (1987).

⁹⁰ INST. OF MED., COMM. ON NURSING HOME REGULATION, IMPROVING THE QUALITY OF CARE IN NURSING HOMES 22 (1986). See also U.S. GEN. ACCOUNTING OFFICE, GAO/HEHS-99-46, *Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards 5* (1999) available at <https://www.gao.gov/assets/230/227015.pdf>.

⁹¹ INST. OF MED., *supra* note 90 at 22.

⁹² 42 U.S.C. § 1395i-3(b)(2) and 42 U.S.C. § 1396r(b)(2) (Under the Act, NFs must also provide residents activities in accordance with the written plan of care).

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for resident nursing care.⁹³ The Act also included a resident “bill of rights” requiring NFs and SNFs to promote and protect the rights of residents to, among other things, be free from restraints, including chemical restraints, imposed for discipline or convenience and the rights of residents to be active participants in the planning of their medical care.⁹⁴ In furtherance of the Act’s intent and policy objectives, the HCFA⁹⁵ issued implementing regulations in 1989 and 1991, establishing the Conditions of Participation (CoPs) for SNFs and NFs participating in the Medicare and Medicaid programs.⁹⁶ However, enforcement of some implementing regulations did not become effective until July 1995, attributable, in part, to the large volume of comments HCFA received during the rulemaking process.⁹⁷

On July 16, 2015, CMS issued a proposed rule to update comprehensively the CoPs for NFs and SNFs participating in the Medicare and Medicaid programs. CMS issued its final rule on October 4, 2016.⁹⁸ The final rule divided the updated CoPs into three phases—with Phase 1 requirements to be implemented by November 28, 2016 and Phase 2 and Phase 3 requirements to be implemented by November 28, 2017 and November 28, 2019, respectively.⁹⁹ CMS estimated that the total projected cost of the final rule would be \$831 million in the first year of implementation, and \$736 million per year in subsequent years.¹⁰⁰

In a June 30, 2017 memorandum, CMS announced that it was imposing a 12-month moratorium on the use of civil money penalties, denial of payment, and/or termination from the Medicare and Medicaid programs, for facilities determined to be out-of-compliance with certain Phase 2 regulations, though noting that the regulations would still take effect on November 28, 2017.¹⁰¹ CMS maintained that it would use the year-long period to “educate facilities about certain new Phase 2 quality standards by requiring a directed plan of correction or additional in-service training.”¹⁰² On November 24, 2017, CMS announced it was extending the moratorium on the enforcement of certain Phase 2 requirements for a period of 18-months, in lieu of the previously announced 12-months, “[t]o address concerns regarding the scope and timing of the revised requirements[.]”¹⁰³

⁹³ 42 U.S.C. §§ 1395i-3(b)(4)-(5) and 42 U.S.C. §§ 1396r(b) (4)-(5).

⁹⁴ 42 U.S.C. § 1395i-3(c) and 42 U.S.C. § 1396r(c).

⁹⁵ The HCFA was renamed the Centers for Medicare & Medicaid Services (CMS) in June 2001. *See* CNN, *supra* note 60.

⁹⁶ 54 Fed. Reg. 5,316 (Feb. 2, 1989) and 56 Fed. Reg. 48,826 (Sept. 26, 1991).

⁹⁷ U.S. Gen. Accounting Office, *supra* note 90.

⁹⁸ 81 Fed. Reg. 68,688 (Oct. 4, 2016).

⁹⁹ *Id.*

¹⁰⁰ *Id.*

¹⁰¹ Memorandum from Dir., Survey and Certification Group, Centers for Medicare and Medicaid Services to State Survey Agency Directors (June 30, 2017) *available at* <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-36.pdf>.

¹⁰² *Id.*

¹⁰³ Memorandum from Dir., Survey and Certification Group, Centers for Medicare and Medicaid Services to State Survey Agency Directors (Nov. 24, 2017) *available at* <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-18-04.pdf>. In its memo, CMS noted that it was not extending the moratorium on regulations that address reporting requirements for the reasonable suspicion of a crime due to the concerns about significant resident abuse going unreported.

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III. ISSUES

The following issues may be examined at the hearing:

- Federal efforts to verify that SNFs and NFs participating in the Medicare and Medicaid programs are meeting the mandatory CoPs, which are intended to ensure that beneficiaries receive the appropriate levels of care and are free from abuse or neglect;
- The role of State Survey Agencies in overseeing SNFs and NFs, and CMS' oversight thereof;
- The consistency and proportionality of enforcement remedies imposed on SNFs and NFs that have been determined to be out of compliance with one or more CoPs;
- Evaluation of SNFs and NFs that have a commonality of ownership;
- CMS' Administration of the Special Focus Facility program;
- Implementation of the emergency preparedness rule and the adequacy of emergency preparedness in SNFs and NFs across the country; and
- HHS OIG's and GAO's work evaluating abuse, neglect, and substandard care occurring at SNFs and NFs.

IV. STAFF CONTACTS

If you have any questions regarding the hearing, please contact Lamar Echols, Christopher Santini, or Natalie Turner of the Committee staff at (202) 225-2927.