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PROMOTING ELDER JUSTICE: A CALL FOR REFORM

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED SIXTEENTH CONGRESS

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PROMOTING ELDER JUSTICE: A CALL FOR REFORM

TUESDAY, JULY 23, 2019

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:15 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Chuck Grassley (chairman of the committee) presiding.

Present: Senators Crapo, Thune, Scott, Lankford, Daines, Young, Wyden, Stabenow, Cantwell, Menendez, Carper, Cardin, Brown, Bennet, Casey, Warner, Hassan, and Cortez Masto.

Also present: Republican staff: Evelyn Fortier, General Counsel for Health and Chief of Special Projects; and John Pias, Detailee. Democratic staff: David Berick, Chief Investigator; Rebecca Nathanson, Legislative Assistant for Ranking Member Wyden, and Joshua Sheinkman, Staff Director.

OPENING STATEMENT OF HON. CHUCK GRASSLEY, A U.S. SENATOR FROM IOWA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. Today we will focus on an issue that has affected many families in Iowa, as well as the entire country: elder justice. Congress has a key role to play in ensuring the protection of our Nation's seniors, as about one in 10 Americans aged 60 and older will fall victim to elder abuse each year.

Many older Americans reside in assisted care facilities, nursing homes, and other kinds of group living arrangements. It is critical that these care facilities and staff not only follow the law but provide the type of care that they would want their own family members to receive.

The U.S. Government Accountability Office just released a new report on this subject today, while the Inspector General at the Department of Health and Human Services issued a related report last month. According to the IG, one-third of nursing home residents may experience harm while under the care of these facilities. In more than half of these cases, the harm was preventable.

We look forward to hearing both agencies' recommendations for Congress at today's hearing. In the 115th Congress, I introduced the Elder Abuse Prevention and Prosecution Act, which was enacted unanimously. It enhances enforcement against perpetrators of crimes targeting older Americans. Specifically, it increases training for Federal investigators and prosecutors, and designates at least one prosecutor in each Federal judicial district be taxed with the handling of cases of elder abuse. The law also increases pen-

alties for perpetrators of abuse and ensures that the Federal Trade Commission's Bureau of Consumer Protection and the Department of Justice have elder justice coordinators.

Next, we need to renew and update the Elder Justice Act. Years ago I joined my colleagues, led by former Chairman Hatch, in developing an earlier version of the Elder Justice Act, which was adopted in 2010. It is time for this committee to revisit the key programs authorized under this important law. It authorizes the Elder Justice Coordinating Council and resources to support long-term care ombudsmen and forensic centers to investigate elder abuse. I am working closely with members of the Elder Justice Coalition, whose leader is testifying today, on legislation to accomplish that goal.

The Des Moines Register last year published reports suggesting a troubling lack of compassionate care for elder residents in some of the nursing homes in my State. Reports also surfaced in 2017 of nursing home workers in at least 18 different facilities taking humiliating unauthorized photos of elderly residents and posting them on social media websites. In the past couple of years, I have seen an uptick in news reports about elder abuse done via social networking.

In response to those reports, I wrote to social media companies to better understand the steps they have taken to prevent their platforms from being a tool of abuse. In addition, I wrote to the Centers for Medicare and Medicaid Services about this very problem. In response, in 2016 that Federal agency issued guidance to State health departments on the misuse of social media in nursing homes to make clear that taking photos and videos of a demeaning nature are forms of abuse.

In March this committee convened an oversight hearing at which we heard from the daughters of two elderly women who resided in federally funded nursing homes. One testified that her mother, an Iowan, died due to neglect in a facility that—can you believe this?—held the highest possible rating, five stars, on a Federal Government website. The family discovered that the nursing home was subject to multiple complaint investigations in recent years.

Another testified about her mother' rape in a nursing home. Many nursing homes offer excellent care, but these and similar cases around the country point to the need for greater oversight.

Families facing the decision to put a loved one in a care facility or a nursing home deserve to have reliable tools to help make the best choice possible. They should not have to worry that their loved one will be abused at the hands of a caregiver.

So I look forward to hearing from all of our witnesses on what more Congress can do to help ensure that government-provided information on nursing homes and care facilities is accurate and reliable, and that oversight efforts will continue to increase quality standards and keep them high and make sure that the taxpayers' money spent on these residences is spent well.

I yield the floor to my ranking member, Senator Wyden.

[The prepared statement of Chairman Grassley appears in the appendix.]

OPENING STATEMENT OF HON. RON WYDEN, A U.S. SENATOR FROM OREGON

Senator WYDEN. Thank you very much, Mr. Chairman.

Mr. Chairman, I want to note that you have a very long history of advocating for the rights of nursing home patients and families. And as far as I can tell, it goes back even to your service in the other body, in the House. You have consistently been pushing for these reforms. I am glad to be able to join you, as I mentioned.

I was, when I was director of the Gray Panthers, the public member of the Oregon Board of Nursing Home Examiners. These are the officials who decide whether to license an administrator. So this is another area where I think there is an opportunity for a set of very significant bipartisan reforms, and I am looking forward to working with you.

Colleagues, today the committee is going to look at what more can be done to protect seniors from abuse and neglect in nursing homes. Based on new reports from the Government Accountability Office and the Inspector General that has, in effect, purview over Medicare, there are two key issues for the committee to confront.

The first is that instances of physical, sexual, mental, and emotional abuse in nursing homes appear to be on the rise. Second, the Federal nursing home rating system does not accurately reflect the prevalence of that abuse. So when it comes to those cases, there are good nursing homes and there are bad nursing homes, and the government is failing to help consumers determine which are which.

So let me begin by outlining how the system is supposed to work. Everybody agrees that even one case—even one—of abuse in a nursing home is one too many. Therefore, State agencies are in charge of conducting surveys of nursing homes and investigating the reports of abuse.

The Centers for Medicare and Medicaid Services is in charge of setting national standards and managing a nationwide rating system for nursing homes. The State agencies and the Federal agencies and CMS are supposed to work in close communication with each other so that families can figure out which homes are safe.

Today, the committee is going to hear that the system is failing the older people it is supposed to protect. The Government Accountability Office studied instances of abuse in nursing homes over a 5-year period from 2013 to 2017. Over that time, the recorded number of instances more than doubled. In a separate study, the Health and Human Services Office of Inspector General also concluded that thousands of cases of abuse in nursing homes go unreported.

Then there is the important issue of the broken rating system. The GAO study found abuse happened in homes of all ratings, top and bottom. A good rating did not indicate that a nursing home prevented abuse.

And now I have to comment on the situation in my home State of Oregon. It was revealed during the auditor's investigation that the State of Oregon went at least 15 years without reporting information on cases of abuse or neglect to the government—15 years worth of records of physical, verbal, mental, and emotional abuse.

Information that Oregonians needed to know in order to keep their loved one safe was unavailable on the nursing home rating system.

Somebody in Oregon who wanted to find out if a particular nursing home had abusive staff would have had better luck reading the local police blotter. Their State and Federal Government failed them.

In May, I wrote to the Centers for Medicare and Medicaid Services urging them to take two key steps. First, I said that they ought to put a warning on their website that the nursing home rating system does not reflect cases of abuse in my State. Second, I wrote that they need to go back and work with Oregon government officials to find all this missing information and fix the rating system so that it is useful and accurate. Anything short of that, in my view, puts older Oregonians in danger.

The office of the Centers for Medicare and Medicaid Services has not yet responded.

Mr. Chairman, I would ask unanimous consent that my letter to them be included in the record at this point.

The CHAIRMAN. Without objection, so ordered.

[The letter appears in the appendix on p. 145.]

Senator WYDEN. And I will just close with this. Ever since I was the director of the Gray Panthers—and this was years ago when I was a young man and I was on that Board of Nursing Home Examiners—I believed that there were good nursing homes in Oregon and across the country staffed by hardworking individuals who excel at their jobs. But not every home meets that standard. That is why we are here.

And in the case of these new reports of studies of vulnerable older people, people living in nursing homes, specifically because they cannot care for themselves, were exposed to unforgivable treatment—thousands of instances of physical, verbal, mental, and sexual abuse, health-care needs unmet, squalid living conditions.

This cannot go on. And the chairman and I have talked about this and have been working on it, and we believe that people who live in Oregon, or Iowa, or across the country have a right to know which nursing homes are safe and which homes are not.

So, colleagues, this is another opportunity in the tradition of the Finance Committee—I see Senator Hassan here, who is always talking about ways in which people can get together, find some common ground. Here is another opportunity for Democrats and Republicans to work together to find solutions on this enormously important issue.

The chairman has demonstrated his commitment to the rights of seniors over the years. Mr. Chairman, I look forward to working closely with you, and I know we are going to uncover some important information today.

The CHAIRMAN. We will work together, yes.

[The prepared statement of Senator Wyden appears in the appendix.]

The CHAIRMAN. First of all, introducing now our first panel—and I welcome both of you and thank you for the work that you put into your testimony today, and also for the work that you do in this area of concern for this committee.

Our first witness is Megan Tinker. Ms. Tinker is the Senior Legal Advisor to the Inspector General at the Department of Health and Human Services. She previously served as a Branch Chief for the Inspector General, directing a team of attorneys in conducting oversight of health programs. Ms. Tinker has audited both nursing homes and group homes.

Our next witness, John Dicken, is Director of the Health Care team at the U.S. Government Accountability Office. He has led GAO's efforts to evaluate nursing home quality for many years. At one time, Mr. Dicken also served as legislative fellow for the Senate HELP Committee.

Welcome to both of you, and I think we will start with Ms. Tinker.

STATEMENT OF MEGAN H. TINKER, SENIOR ADVISOR FOR LEGAL AFFAIRS, OFFICE OF COUNSEL TO THE INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Ms. TINKER. Good morning, Chairman Grassley, Ranking Member Wyden, and other distinguished members of the committee.

Thank you for the opportunity to testify about the urgent need to protect Medicare and Medicaid beneficiaries from abuse and neglect. As our work shows, far too often abuse and neglect are hidden and unreported, leaving deficiencies uncorrected and beneficiaries at risk.

Unfortunately, in almost every care setting, we have found troubling failures to identify, report, and address abuse and neglect. When lapses occur, the results can be devastating for beneficiaries and their families. For example, we uncovered the abuse of an 85-year-old woman residing in a long-term care facility. The owner beat the resident with a broomstick. She was covered with bruises, tied to a wheelchair, and her mouth was taped shut.

We learned about a group home owner who forced residents to fight each other. As a result, a resident died. And the owners and employees tried to cover up the death by encasing his body in cement and hiding his body in a storage facility.

In hospice, we have uncovered pressure sores leading to gangrene and limb amputations, maggots around a feeding tube, and many other disturbing examples of abuse and neglect.

We know that most providers are delivering good care. However, our work reveals an alarming rate and range of potential abuse and neglect and missed opportunities to prevent it. Fundamental common-sense safeguards are lacking.

First, data is not being used effectively to identify potential abuse and neglect. Second, potential abuse and neglect are not always being reported to law enforcement or State agencies. And finally, States are not ensuring that identified problems are corrected.

With respect to our first safeguard, CMS, States, and providers need to use the data they have to identify potential abuse and neglect. That is what we did. Data forms the bedrock of oversight and ensures transparency and accountability.

By analyzing the data, we found that one in five high-risk Medicare emergency room claims for nursing home residents were the

result of potential abuse or neglect. We also found that Medicare beneficiaries, regardless of the setting, are vulnerable to potential abuse and neglect.

Most incidents did not occur in medical facilities. In the majority of incidents, the likely perpetrator was a spouse or a family member. Medicare claims data is a powerful tool to fight against abuse and neglect, yet CMS does not agree with our recommendation to mine this data.

Second, it is critical that potential abuse and neglect are reported. CMS, State agencies, and law enforcement cannot protect beneficiaries from harm if they do not know it is occurring. In nursing homes, we found approximately 27 percent of potential abuse and neglect incidents were not reported to law enforcement as required.

We found similar problems in group homes. Worse, in hospice, Medicare only requires reporting when potential abuse or neglect involves a hospice worker, and the hospice has investigated, and the hospice has verified the allegation. This lack of reporting leaves vulnerable beneficiaries unprotected.

Third, prompt action is needed to correct deficiencies at facilities that result in abuse and neglect. Our work raises concerns about State oversight of problematic facilities. We found that seven States did not always verify that nursing home deficiencies were corrected.

Approximately 31 percent of those nursing homes had a repeat deficiency. At least half of those nursing homes had more serious deficiencies, including substandard care, actual harm, and immediate jeopardy. Ensuring that deficiencies are corrected is essential to the health and safety of nursing home residents.

So how can this be improved? My written statement recommends some specific corrective actions to help improve oversight. Chief among them, CMS should make better use of the data at its disposal to help prevent abuse and neglect. Today we released a guide that provides a roadmap for CMS, States, and providers to identify unreported abuse or neglect. This, in turn, can lead to targeted oversight and enforcement actions to prevent future harm.

The problem of hidden unreported abuse and neglect requires urgent attention to protect our most vulnerable beneficiaries. Thank you for your ongoing leadership in this area and for the opportunity to testify before you today.

[The prepared statement of Ms. Tinker appears in the appendix.]

STATEMENT OF JOHN E. DICKEN, DIRECTOR, HEALTH CARE, GOVERNMENT ACCOUNTABILITY OFFICE, WASHINGTON, DC

Mr. DICKEN. Chairman Grassley, Ranking Member Wyden, and members of the committee, I am pleased to discuss GAO's new report released today titled "Nursing Homes: Improved Oversight Needed to Protect Residents From Abuse." This is the most recent from more than 20 years of GAO reports finding that too many nursing home residents are subject to abuse and that, despite ongoing efforts, weaknesses remain in oversight intended to ensure residents' safety and welfare.

Abuse of nursing home residents remains relatively rare, representing less than 1 percent of all nursing home deficiencies sub-

stantiated by State inspectors and reported by CMS. However, we found that the number of abuse deficiencies more than doubled from 430 in 2013 to 875 in 2017. The largest increase was in severe cases causing actual harm or immediate jeopardy for residents. The increased frequency and severity of abuse deficiencies is disturbing, but it is important to note that CMS officials and stakeholders we interviewed agreed that abuse remains under-reported.

To further understand the types of abuse reported, GAO reviewed a representative sample of 400 narratives describing abuse deficiencies reported in 2016 and 2017. More than half, 58 percent, identified nursing home staff as the perpetrators. Other residents were the perpetrators in 30 percent. Physical abuse was identified in 46 percent of abuse deficiencies.

One example was a nurse aide who grabbed a resident by both wrists, causing the resident to fall, bruising their wrists and hip. In another example, a resident kicked another resident in the face, and a third resident shoved and then hit a fourth resident and also slapped a fifth resident.

Mental and verbal abuse was identified in 44 percent of abuse deficiencies. Examples include a family member visiting a resident who threatened to take another resident out of her wheelchair, leaving that resident frightened and with nightmares.

Another example: a nurse assistant swore at and told a resident to shut up when asked to change his soiled brief, and put the call button out of the resident's reach under his bed.

Sexual abuse represents 18 percent of abuse deficiencies. These include a resident with a history of such behavior who grabbed two other residents in a sexually inappropriate manner. In another case, a nurse aide found a medical technician sexually assaulting a resident who was nonverbal with severe dementia and totally dependent on staff for mobility.

In my remaining time, I will highlight GAO's recommendations to address several shortcomings in CMS's oversight.

First, we recommend that CMS require State agencies to report abuse, perpetrator, and type, and systematically assess these trends. This could help tailor prevention and investigation efforts and identify gaps, if the results are not aligned with CMS's expectations.

Second, we recommend that CMS develop and disseminate guidance, including a standardized form on information nursing homes should report to States when incidents occur. Nearly half of abuse deficiencies originated from facility-reported incidents. However, State officials told us that documentation from nursing homes often lacks information needed to triage whether and how promptly to investigate.

Third, GAO recommends that CMS confirm that all State survey agencies are investigating abuse allegations and sharing their results with CMS. As Ranking Member Wyden noted, this finding is based on a finding for Oregon, where for more than 15 years another agency, not the survey agency under contract to CMS, investigated certain nursing home allegations. CMS did not get those investigation results, and they were not included on their website. Oregon changed this practice in late 2018, but CMS needs to en-

sure that no other States have similar compliance, and that Oregon consumers have complete nursing home abuse records.

Finally, GAO recommends that CMS require State agencies to immediately refer any suspicion of a crime to law enforcement to address existing gaps that can delay or miss referrals to enforcement.

We are pleased that CMS concurs with each of our recommendations and plans to take steps to address them. The sustained focus is critical to ensure that residents in nursing homes receiving Medicare and Medicaid payments are free from abuse.

This concludes my prepared statement. I would be pleased to respond to any questions the committee may have.

[The prepared statement of Mr. Dicken appears in the appendix.]

The CHAIRMAN. We will have 5-minute rounds of questions.

The first question is, Ms. Tinker, I have a constituent, Ms. Miller, whose father, Duane Dingman, a military veteran from Webster City, IA, passed away in a nursing home. She reports he died because of being denied his heart medication by nursing home personnel for 5 days. She urged that we require nursing homes to get a family member's signature before denying essential medication to a patient.

Is Mr. Dingman's case atypical? Or do you often hear of similar cases about life-saving medication? And what is your reaction to my constituent's suggestion?

Ms. TINKER. We are certainly aware of multiple cases where medication has been an issue. And in fact in our report, where we looked at the data about what were the top-ten deficiencies, one of those was an issue around medication errors. So we are aware that those are problems, as part of the data brief that we issued earlier this year.

And it is very unfortunate and concerning that these types of things have occurred. And that is part of why we continue to recommend to CMS that they look at the data to clearly identify where potential abuse and neglect occur, and to be in a position to actually target resources to those risk areas.

The CHAIRMAN. Last, your study indicated that there are problems not only with nursing homes, but with group homes and hospices. The problems are similar. For example, your report seems to suggest that neither group homes nor nursing homes routinely report serious cases to State officials, and even when they do, most of them are not forwarded by State agencies to law enforcement for investigation.

Number one, is that accurate? But what other similarities and what differences do you find in audits of both kinds of facilities?

Ms. TINKER. That is accurate. What we found in both the group home context as well as in the nursing home context was a lack of reporting at the beginning, by either the nursing facility or the group home. But even when those incidents were reported, they were not necessarily followed through and properly investigated.

This raised for us significant concerns. The largest difference in both of these two different populations is really how they are regulated.

In the group home context, the primary regulatory structure is around State-specific rules and regulations. And so there is a lot

of variation in how those particular facilities are governed, which is part of why we issued our Joint Group Home Report, which provided model practices to States, giving them a roadmap for how to conduct comprehensive compliance oversight to prevent incidents of abuse and neglect.

In the nursing home context, there is a joint Federal and State oversight structure that is more comprehensive in some ways, because it relies on the Federal Conditions of Participation and State survey agencies.

The CHAIRMAN. Mr. Dicken, Senator Wyden and I, along with the Homeland Security Committee members, jointly requested the report which was released today.

Question number one: we have heard from prosecutors that State nursing home inspectors focused closely on compliance with their regulatory checklist but not so much on closely collaborating with law enforcement when there is evidence of a possible crime.

Do you agree?

Mr. DICKEN. Yes. We did hear that there were concerns that information from the State inspectors was not being conveyed as timely or as completely to law enforcement.

The CHAIRMAN. To you also, do State and Federal inspectors receive adequate training on signs of abuse and neglect before conducting periodic inspections of long-term care facilities? What more could be done to encourage greater collaboration, if it does not exist?

Mr. DICKEN. Yes, thank you. Inspectors do undergo training, but certainly we did have recommendations that there be more clear guidance on the situations when there is a suspicion of crime and that that should be immediately referred from the State inspectors to law enforcement.

We heard from some State agencies that there was currently confusion as to what extent those could be referred before they were substantiated, and we recommend that those should be referred immediately when there is a suspicion of crime.

The CHAIRMAN. Senator Wyden?

Senator WYDEN. Thank you very much, Mr. Chairman. I want to thank both of you for your professionalism, and I have questions for both of you.

Ms. Tinker, let me start with you, and going back to my roots as the public member of the Nursing Home Board at home in Oregon. What we were concerned about in particular was the hiring process, because people wanted to know the backgrounds of folks who were being hired to care for those whom they loved so much, their seniors. And we wanted to know whether nursing homes were hiring people who had committed crimes against seniors or other vulnerable people. And families are trying to get that information, obviously, as well.

So as of this morning, are criminal background checks being used across the country in a reliable kind of way to prevent dangerous people from being hired to take care of the Nation's older people?

Ms. TINKER. We recently issued a report looking specifically at the National Background Check Program for Medicaid, which obviously touches on some of these areas. And what we found was that

13 States still have not implemented background checks, and loopholes——

Senator WYDEN. No background checks at all?

Ms. TINKER. Some of those 13 States are in process of implementing, and others no.

Senator WYDEN. And what about—okay, what about all of the States with respect to hiring dangerous people? Can you give me anything resembling a ballpark kind of assessment of how many States still have laws that could allow for the hiring of dangerous people?

Ms. TINKER. What I can tell you, based on our work, is that those 13 States that are outstanding continue to raise concerns. And let me tell you a little bit about the loopholes that we found, which would be applicable across all States, and that raised concerns——

Senator WYDEN. This is very helpful. You are going to talk now—we have 13 States that are really a problem, but you are going to talk about all the loopholes that apply generally with respect to hiring?

Ms. TINKER. Absolutely.

Senator WYDEN. That is very helpful. Go ahead.

Ms. TINKER. There are two loopholes that we found as part of our work in the background check report that we issued earlier this month.

The first loophole is that right now State Medicaid programs, when enrolling a provider that is high-risk, can in fact, if the provider is already enrolled in Medicare, forego a background check. However, that is even if Medicare themselves did not perform a background check.

So that leaves open the possibility that somebody could become a provider for Medicaid and not have any background check in place. And when we recommended to CMS that they close this loophole, they did not concur with our recommendation.

The second loophole I will tell you about today is that one of the other big problems is that when background checks are being performed, we are looking at ownership structures and who is responsible for providing care. As part of that, providers are required to self-attest their ownership. Many States do not verify who the owners are, which means that there could be criminals who are part of the ownership structure that we would have no awareness of and who would not have background checks performed.

Senator WYDEN. Thank you. And I just want you to know that the chairman and I and our very talented staff feel really strongly that there have to be robust background checks. And it ought to be from sea to shining sea. It is time to end this kind of lurching from one piecemeal approach or another and give families the security with respect to folks being hired. So we are going to follow up with you very closely on this.

There is one matter I have to go into, in the remainder of my time, with Mr. Dicken, but I just wanted you to know that Chairman Grassley and I feel very strongly about closing these loopholes that you have described and background checks everywhere, period, full stop.

Mr. Chairman, thank you. And I just wanted—I know you have a tight schedule. I am going to ask just one other question really

quickly, but I appreciate working with you on the background checks.

The CHAIRMAN. Then Senator Lankford will be next.

Senator WYDEN. Okay. Very good. On the rating system, Mr. Dicken, let me just kind of get to the bottom line. It is a mess, and it is hard for people to figure out what it means in terms of all of these issues relating to the abuses. You all seem to have made some recommendations about how to fix it.

Why don't you just tell us what those are?

Mr. DICKEN. In past reports, GAO has made recommendations to try to improve the rating system. On some of that, CMS has made some steps and provides consumers more information about how the rating system is calculated.

We also, though, have recommended that CMS provide more information, for example on consumer satisfaction, which they have not yet done but concurred with.

We have also recommended that they make the information more comparable nationally. If I am a resident of Maryland and I have an aunt in a nursing home in Delaware, I cannot compare——

Senator WYDEN. How do you make the information about abuse more available to families and patients?

Mr. DICKEN. Right. So right now abuse is only one of the pieces of information that is indicated. And as noted, many of the homes that we found that had abuse ran the full gamut of the star rating system. And a consumer right now would have to click through multiple pages on nursing homes to get to information on abuse. There would need to be more direct information more prominently that would be indicating where there would be abuse citations found.

Senator WYDEN. Okay. I am over my time. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Lankford?

Senator LANKFORD. Thank you, Mr. Chairman.

I want to come back to this background check issue. There are 13 States currently that are not doing background checks for employees who are there—or ownership, obviously, as you mentioned the loopholes before.

Does that include States that only do a State background check but not a national background check? Are there some States that are only doing a State criminal check but not doing national——

Ms. TINKER. Yes. Part of the 13 States is States that might have current State background checks in place but have not, for high-risk providers, fully gone through the process of implementing national criminal background checks.

Senator LANKFORD. So the other 37 States all do a full national criminal background check, not just a State only?

Ms. TINKER. Absolutely. However, there are these loopholes that do allow for some opportunity to not perform those background checks.

Senator LANKFORD. I want to go back to the rating system. These were similar—my questions—to what Senator Wyden was also talking through before. The number of employees or individuals who may be in the system that there may be a problem with, is that counted into the rating system currently? Can you get a five-

star rating and have employees who have been on the sex offender registry, or have a history of abuse?

Mr. DICKEN. Yes; the rating system does not directly look at that. It does look at the broader issues of staffing, and of inspections, but it is not directly related to that particular issue of whether——

Senator LANKFORD. Is that something that there is a recommendation for to say a history or previous recordings of abuse in this facility need to go into the rating system in the future?

Mr. DICKEN. So we have certainly recommended that the information on abuse be contained—you know, we made a number of recommendations that would help to identify those. Those would indirectly feed into the rating system, but not tie directly to the registry.

Senator LANKFORD. We have a tremendous number of really high-quality facilities in Oklahoma with staff who love the folks they serve with, and love getting the chance to serve seniors in all of that care. Have you been able to note in any of your previous work what denotes to a family when they are looking, what are the common characteristics of really high-quality care facilities?

For instance, local ownership. Transparency in data. Relationships with local hospitals. Allowing cameras to be in facilities owned by the patient's families.

Have you noticed certain things that, if those things are present, there seems to be a higher-quality, less-abusive facility?

Mr. DICKEN. We did talk to nursing homes, as well as to inspectors, about some of the challenges and issues that would be in homes that were more or less likely to have abuse. Many of those related to staffing. We heard from staff whom we spoke with directly that in some homes they had resources that, if there were a difficult situation, if they were stretched, they could turn to other staff who could relieve them. Other homes, they said they really did not have that flexibility to turn to other staff, and they felt under-staffed and over-stressed.

We also heard that there were more challenges often in homes that might have a diverse population, including both elderly and younger residents, both with cognitive issues as well as other issues, and that that posed more challenges. Certainly consumers need to look not only at the five-star rating, but other information that is available, and talk to the nursing home ombudsmen and others to find out how they are performing.

Senator LANKFORD. So how would individuals get that information?

Mr. DICKEN. Well, the starting point can be the information on Nursing Home Compare, but going beyond that to talking to ombudsmen, to discharge planners in hospitals that may know more on local situations. It is certainly important to visit the homes and to talk to the staff in those places.

Senator LANKFORD. So several years ago this Congress worked with FAA and air traffic control to be able to set up a system in place that FAA led the way on. So if there was a mistake made by a controller, aircraft got too close, in the past they were scored low on that, and so they were trying to hide that. They transitioned that to say, no, we want the mistakes to be more public on this,

and we want to find a way to be able to get more information out on reporting.

A lot of our conversation today has been about reporting. How do we get information out so that, if something occurs, it is not hidden?

Do you have recommendations for how to change the way we do reporting to increase the number of reports, and so then we can make the changes that are necessary?

Mr. DICKEN. Yes, we did recommend that CMS revisit the information that facilities are required to report when an incident does occur. That requirement exists now in nursing homes, for the homes, but we found that often the information was not as timely——

Senator LANKFORD. If there is a disincentive to report, then you are going to get fewer reports. But we need more information, not less, at the end of the day. And so I think that would be an area that we need to continue to be able to find what is a better way to be able to get more information out so that we do not have folks hiding it with a disincentive. But we have to get that out in the daylight.

Mr. Chairman, thank you.

The CHAIRMAN. Thank you. Senator Stabenow?

Senator STABENOW. Thank you, Mr. Chairman. And thank you to you and our ranking member for continuing to keep a focus on this incredibly important issue. And thanks to both of you for your reports and your professionalism around this issue as well.

I want, before asking questions, though, to just underscore something, when we are talking about the fact that Medicaid covers two out of three nursing home residents. Medicaid covers two out of three nursing home residents in our country, and we need to protect and strengthen Medicaid to make sure that seniors and people with disabilities are able to get the high-quality care that they need and deserve.

And I say this only in context as we are doing budget negotiations, because the President's budget cuts $1.4 trillion—trillion dollars—out of Medicaid and would make it even harder for nursing homes to maintain quality staff and care for loved ones. Now, we are not going to let that happen, but that is important in all of this context.

When we look at this issue—and we all have or will find ourselves in a situation where we are looking for appropriate care, nursing home care, other kinds of long-term care for loved ones. So this touches each and every one of us. And we know that we have great nursing homes, great staff doing wonderful work around the country—and we know that is the majority, but it is horrific what you were saying about the cases where we, in fact, are finding abuse.

At our last hearing, we heard from Ms. Patricia Blank, whose mother died from dehydration and neglect, and as the chairman talked about, Ms. Maya Fischer, whose mom was raped. And yet when we go to the website, the CMS Nursing Home Compare website, I was shocked to see that one of the nursing homes had a five-out-of-five quality measure rating, and the other had a four-out-of-five staffing rating.

So obviously this is not working, and people cannot find the information that they need. So when we look at the situation—you talked about various pieces so far—what can CMS do immediately? And what would you recommend that we do legislatively? Ms. Tinker first.

Ms. TINKER. The most important thing that CMS can do immediately is look at the data in a comprehensive way, much like we did and much like the guide that we released today recommends, so that they can identify risk areas. Where are the problems happening? That is what the data will allow us——

Senator STABENOW. So they have data. They are not using it. They could make it a priority if they wanted to, because they already have the data. Is that what you are saying?

Ms. TINKER. Yes. And then target resources to those risk areas that the data demonstrates are problems.

In terms of legislative solutions, one of the legislative solutions we have recommended is providing Medicaid Fraud Control Units, which are really on the front lines of combating, investigating, and enforcing the abuse and neglect issues, broader authorities. Currently they are limited and can only investigate and enforce abuse and neglect that occurs within institutional facilities. But, as our data shows, many Medicare patients are actually experiencing harm in their homes or in public venues.

And broadening MFCUs' authority so that they can investigate and enforce abuse wherever it occurs, I think would be a good step forward.

Senator STABENOW. Thank you. Mr. Dicken?

Mr. DICKEN. Yes. I think we had some very complementary recommendations to CMS regarding, or that could immediately provide guidance that would clarify that the suspicion of crime needs to be immediately referred to law enforcement to provide more information. And if they could have more information on the abuse that is occurring, they could better target their prevention and investigation into those types of abuse and limited resources. So a number of steps I think are very complementary across recommendations to agencies.

Senator STABENOW. Thank you. And then finally let me ask—we have the Elder Justice Act. In light of that fact, OIG informed CMS in 2017 that it had inadequate procedures to ensure the incidences of potential abuse and neglect are properly identified and reported. So we now have the Elder Justice Act, which includes reporting requirements, but they have not been conveyed to CMS from HHS.

So could you talk more about why Health and Human Services has not directed CMS to enforce the reporting requirements that were put into law?

Ms. TINKER. That is not something I can directly address. I think you would have to talk to the Department about why that decision has not been made or put together at this point.

Senator STABENOW. Mr. Chairman, I would say we passed a law, and that information at this point, those reporting requirements are not being enforced. And I think that is an important——

The CHAIRMAN. Why don't we take her suggestion, and you and I can inquire by letter to the Department——

Senator STABENOW. Thank you.

The CHAIRMAN. And I will sign it with you.

Senator STABENOW. Thank you very much, Mr. Chairman.

The CHAIRMAN. Senator Daines?

Senator DAINES. Mr. Chairman, thank you for holding this hearing today, and thank you for making it a priority to address the abuse and neglect we are seeing in nursing homes.

When it comes to family members making a decision to find a nursing home for a loved one, the last thing they should be worried about is whether mom or dad, a grandfather, a grandmother will be safe from abuse in their new home.

While there are a number of high-quality nursing homes across Montana, I am very concerned by reports that some of our most vulnerable patients have experienced serious harm. Procedures must be in place to prevent abuse from happening in the first place and improve the quality of care in nursing homes that are struggling. It is time to push past the status quo.

I am very glad our committee is discussing reforms to combat nursing home abuse. I look forward to continuing to work with the chairman to protect seniors in Montana and across our Nation.

I heard a very troubling story recently regarding a State-run nursing home in Montana that has been cited for failing to protect patients from harm. According to a former employee of a facility in Lewistown, MT, when she tried to report quality issues, nursing home administration officials took retaliatory actions against her.

When she brought concerns to leadership, she was excluded from meetings in the building, and she ultimately resigned. I have been told that despite multiple citations, fines levied against the nursing home, and hundreds of thousands of taxpayer dollars being funneled to this facility, no one in a leadership position at this facility has been held accountable yet.

When a Montanan brings a serious concern to me, it is one of my duties to look into it.

Ms. Tinker, can you commit to working with me to ensure that Montana seniors are protected from nursing home abuse?

Ms. TINKER. Yes. OIG is very committed to beneficiary health and safety across the board, both across the country and across all service settings, especially in nursing homes.

Senator DAINES. And what then can be done to ensure that those coming forward with reports of mistreatment are taken seriously?

Ms. TINKER. Again, I think one of the most important things that can be done, and one of the recommendations that we continue to make, is that CMS first use the data to identify risk areas, but then do more in terms of training and guidance both to nursing facilities and to State survey agencies about reporting and how to properly address those types of issues, similar to the recommendations that my colleague, Mr. Dicken, has also made.

Senator DAINES. So, since our first nursing home hearing in this committee, I have had several Montanans reach out to me asking for help about how to submit a complaint regarding a nursing home. Whether the complaint was related to poor care, unsafe conditions, the feedback I received was the same: the current process for filing a grievance was cumbersome, as well as confusing.

I am curious if GAO or the HHS IG has had any similar findings. Mr. Dicken, in your testimony you mentioned that abuse in nursing

homes is often under-reported by residents, family, staff, and the State survey agency. Why is that? And what are the current barriers to reporting?

Mr. DICKEN. There are a number of issues. I think, Senator Daines, you mentioned one, which is, for staff, it is fear of retaliation. That was something you spoke to about the home in Montana. Certainly the need is to be able to report, whether it is from staff or from the nursing home itself, or from family members or other visitors—people report effectively and efficiently, and so that is the triage, so that the State agencies are responsible for investigating those and can triage them to do prompt investigations as needed and consider them as part of the annual survey process.

And so the fear, as well as extensive reporting, is a real issue. Complaints and facility-reported incidences are particularly important in situations of abuse, where waiting for an annual survey is maybe too long.

Senator DAINES. So before I came to Congress, 12 years prior to that, I was in the cloud computing business, the customer experience business, helping companies and organizations improve customer experience. Oftentimes it is a company's, an organization's starting with the inside and working out. Have you tried working with a group of seniors, a focus group, saying, "Try filing a complaint or a grievance and see how cumbersome and confusing it can be"? In other words, start working from the outside and work your way in with the folks on the front lines here who are trying to get help.

Mr. DICKEN. Yes, we welcome your suggestion on that. We did talk to both residents and staff during the course of our work, but certainly that is important to hear from families and consumers themselves, residents themselves.

Senator DAINES. Okay. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Menendez, you can go ahead. Senator Carper was waiting to be next, but you are ahead of him.

Senator MENENDEZ. I just offered to Senator Carper, if he needed to go, that I would yield to him.

The CHAIRMAN. Okay.

Senator CARPER. Mr. Chairman, I have a student out here, and I am going to let them wait for 5 minutes to get a civics lesson.

So, Bob, you go ahead. Thank you for your kindness.

Senator MENENDEZ. All right. Thank you, Mr. Chairman.

Ms. Tinker, a recent report found that New Jersey nursing homes are under-staffed, and that trend seems to be occurring nationally. For workers providing care for the elderly or those with complex medical needs, it is not an easy job. It is both mentally and physically draining.

GAO found that the majority of abuse occurring in nursing homes is perpetrated by staff. Do you think that better accountability and reporting throughout the system would lead to improved workplace environments and reduce some of the staff shortages that likely lead to circumstances where abuse may occur?

Ms. TINKER. We don't have any work that directly looks at the issue of staffing and how reporting and staffing would work together. However, we recognize it is a serious issue, and we do have ongoing work right now looking specifically at staffing in these

types of facilities. And when it is finished, we would be happy to come and brief you and your staff on it.

Senator MENENDEZ. I will look forward to that, because there has to be some correlation and at least some transparency in this process.

Mr. Dicken, I would like to dig a little deeper into the process for reporting abuse. CMS only requires a State survey agency to refer a case to law enforcement after they substantiate the claim. Law enforcement is brought into these matters quite late in the process.

Would a unified reporting system, one that requires immediate reporting by the nursing homes into a platform that would simultaneously send those cases to CMS, law enforcement, and State agencies, reduce delays and better flag potential abuse cases?

Mr. DICKEN. Well, we did recommend that CMS provide guidance to allow for that immediate referral. We did not specify the tools or the system that would do the reporting, as you are suggesting, but did recommend that CMS clarify and find tools that could provide more immediate reporting from State agencies to law enforcement.

Senator MENENDEZ. So if there is a—if you gave them that advice, obviously that flows from a view that having that reporting take place in a timely fashion is of value.

Mr. DICKEN. That is correct.

Senator MENENDEZ. So if we had a platform in which the reporting goes to CMS, law enforcement, and State agencies, everybody would know. Everybody would be on notice, and the ability to respond at an earlier period of time would be, I would think, of far more value.

Am I missing something in that regard?

Mr. DICKEN. Certainly sharing common information with all relevant, whether law enforcement, State agencies, Adult Protective Services, Medicaid Fraud Control Units—it is important that all the key actors here have the information.

Senator MENENDEZ. Let me ask you just one follow-up. What potential barriers are there to unifying a reporting system, not only for abuse cases but to better track and weed out staff who have histories of abusive behavior?

Mr. DICKEN. We have not specifically examined the type of common reporting system you have looked at, so I cannot speak to the barriers of that specific reporting system. Certainly there is current reporting, whether it is from the facility, from the States, but they have different roles, whether it is a criminal investigation looking at administrative deficiencies for homes that receive Medicare and Medicaid, or being advocates for making sure the elder individuals are safe in all settings, whether it is nursing homes or others. So they do have different roles and jurisdictions. They do overlap, though, when there may be criminal activity that has led to abuse in nursing homes.

Senator MENENDEZ. Ms. Tinker, let me ask you this. The National Background Check Program establishes the means to vet nursing home employees, but only a handful of the 25 States that participated in the program successfully implemented the required range of background checks. Eight of the 10 that completed the

program found nearly 80,000 applicants ineligible. These examples demonstrate the importance of background checks for protecting nursing home residents.

Why do you believe that background checks have not been more widely adopted? What are the barriers for States in doing so?

Ms. TINKER. Some of the barriers that we identified in our report around background checks were things like requiring State legislation to be able to utilize that information. And national criminal background checks are fingerprint-based, which is part of why State legislation was often required.

In addition, doing this kind of work also often requires additional funding to be able to actually make sure that the appropriate infrastructure is in place at the State level.

The CHAIRMAN. Senator Carper?

Senator CARPER. Thanks, Mr. Chairman. Again I want to thank my colleague, Senator Menendez, for his kindness.

To our witnesses, welcome. We are delighted to see you here. GAO folks, we thank all of you for the work you have done in the last 2 years in response to requests made by Senators Portman and Grassley, Wyden, and myself. We are grateful for that.

I think we could probably go around the members of the committee and everybody could tell a story about their mom or their dad or grandparent, aunt or uncle, who lived the last years of their lives in a nursing home. For my sister and me, the story would be our mother, who suffered from dementia. And at the age of about 80, we moved her up from her home in Florida. Of course she was actually cared for in her home by a home health agency, which was comprised of members of her church. They were like a gift from God, taking care of my mom for the last year that she was in Clearwater.

My sister found a wonderful nursing home in Ashland, KY, about halfway between my mother's sister in Huntington and my sister in Winchester, KY, and my mom lived there for the last 3 or 4 years of her life. They were a gift from God as well. They took great care of my mother, and I will always be grateful to them.

Ironically, my sister, when we were going through my mom and dad's things at the house before we were to sell the house, my sister came across an insurance policy that provided for 2 years of care for someone, in this case my mother, in a nursing home. We had no idea she had bought it.

She also somewhere along the line in dementia put a new roof on the house that she didn't need, and she paid more for a vacuum cleaner than I would pay for some cars I have owned, but she got that 2-year policy that was just a huge help for her and for me.

Any one of us could tell our own story, but we have been blessed with just great care for someone who was just very, very dear to us.

Mr. Dicken, you mentioned that Delaware is one of the five States that GAO studied as part of its review. Based on the data you collected, in what areas have the nursing homes in Delaware performed well? And in what areas do we still need some improvement?

Mr. DICKEN. Thank you, Senator Carper, and thank you for working with us, along with Chairman Grassley and Senator Wyden and Senator Portman, on requesting our work.

Delaware was one of the five States that we reviewed, and we spoke to the State agency, talked to the nursing homes, talked to others that were in the State. And we really heard common themes in many cases across States about the investigations, about the very strong care that was going on, as you indicated, but also the challenges of investigating.

We saw abuse cases, as you know, in every single State. Delaware was a State that had abuse reported in a half-dozen homes during the 5 years that we reviewed. And so certainly the Delaware officials we spoke with provided similar information about the challenges of investigating, the importance of doing that in a timely manner, and making sure that both deficiencies that were cited in Delaware as well as in every other State would lead to effective correction of the problems that were identified.

Senator CARPER. All right; thank you. And I have one question for Ms. Tinker.

Ms. Tinker, the Office of Inspector General for the Department of Health and Human Services has released several noteworthy reports on nursing home abusers over the last few years, as you know. Could you just explain to us how the Centers for Medicare and Medicaid Services are working to address the recommendations in these reports? And a follow-on, related question: how many recommendations made by your office to CMS are still outstanding?

Ms. TINKER. Just yesterday, we released our report on our top recommendations that demonstrates what those top recommendations are that are outstanding currently with the Department as a whole.

In terms of our recommendations around nursing homes specifically, many of those recommendations have been accepted by CMS. They concurred. But the most important recommendation, however, is one around data, as I mentioned earlier and in my written testimony. And that is a recommendation with which CMS has not concurred. We looked at all of the data related to Medicare beneficiaries, regardless of the setting, that indicated possible and potential abuse or neglect. And we utilized that data to identify risk areas and provided that information to CMS, as well as the guide that we released today, which really step-by-step goes through the methodology that we utilized. And yet CMS still continues to disagree with that particular recommendation and has not agreed to implement it.

Senator CARPER. All right. Well, thank you. Just very briefly, Delaware was the first State to ratify the Constitution, which leads off with the Preamble, which says something like, "We, the People of the United States of America, in order to form a more perfect union"—it does not say to form a perfect union. Everything we do, we know we can do better. This is one area where we are doing better, I think, and we need to do better still. We thank you for your help in getting us to that goal. Thank you.

The CHAIRMAN. Senator Cardin?

Senator CARDIN. Well, thank you, Mr. Chairman, and thank you for conducting this hearing. I want to thank both of our witnesses for what they do every day.

I have visited many of the nursing homes and skilled nursing facilities in Maryland, and, as was pointed out by our witnesses, most do their work in a highly professional manner with great concern about the patients that they are taking care of, and great pride in doing it. So it is in everyone's interest that we get this issue about abuse done right, because there is a general view that is felt when there is an abuse in any nursing facility. So I appreciate the work that is being done.

Ms. Tinker, you mentioned in your report something that I find very concerning. That is that most of the actual instances that cause harm occur in settings other than medical facilities.

Maryland's Attorney General Frosh informed us that the Medicaid Fraud Control Unit cannot investigate matters of abuse outside of institutional settings because of the way the contract with CMS is worded.

So my question to you is, how do we correct that? How do we deal with where the majority of the abuse is taking place in non-institutional settings?

Ms. TINKER. We currently have a recommendation that is open, asking for a legislative change that would actually increase the statutory authority granted to Medicaid Fraud Control Units so that they would be able to investigate and enforce potential abuse and neglect issues outside of those institutional facility settings. And we believe that is actually more important than ever, as more individuals are receiving care in their homes through personal care services, hospice, and home health.

Senator CARDIN. So will you make available to this committee the language you believe is necessary in order to make that correction?

Ms. TINKER. We would be happy to give you that information.

Senator CARDIN. Thank you. I appreciate that.

Both of you have referred to the importance of data. And both of you are indicating CMS is not providing adequate data to be able to identify the abuse by perpetrator or the type, et cetera. And both, I believe, are making recommendations that CMS should change that, but you are not getting the cooperation from CMS. Is that what I understand?

Mr. DICKEN. GAO did make a recommendation that CMS should have more readily available information on perpetrator and type. CMS did agree with our recommendation and indicates that they will take steps to do that. But, you know, that is a new recommendation.

Ms. TINKER. OIG recommended that CMS look across all Medicare beneficiary data to look at specific diagnosis codes for potential abuse or neglect, and that recommendation is one that CMS did not agree with.

Senator CARDIN. And that is why I am harping on this right now, because, Mr. Dicken, you indicated that the data is necessary in order to know where you can target investigations, but also for prevention that it is critically important. And I want to talk about prevention for 1 second.

I think we all want to see changes that make abuse less common. And as you pointed out, some of the abuse is under the direct control of the facilities, and in other cases it is the residents who are causing abuse. But there are steps that can be taken to mitigate that.

So my question is, from the information you have, are we taking appropriate steps to prevent abuse? We are all harping on how we can get more investigations done and better reporting, which I support, but do we have views as to how we can mitigate the potential for abuse today?

Mr. DICKEN. Well, it is certainly at a place where there are steps being taken, but certainly more could be done. That is why we did recommend that there be more information that could help target those prevention efforts.

Senator CARDIN. I understand you want more information, but with what we know today—obviously, we are always impetuous for safety issues, and rightly so. Do you have any observations as to steps that could be taken today to mitigate the potential for abuse?

Mr. DICKEN. Well, I think what we heard, when we interviewed nursing home inspectors for the key issues, were things like screening staff. That has been talked about today: training staff and making sure that information is known. And then for the consumers, be vigilant. Family members should be visiting, other advocates, and an ombudsman should be present.

So some of that is happening now, but certainly a continued, sustained focus on those, and continued training and screening efforts are still needed.

Senator CARDIN. Ms. Tinker, do you have additional points?

Ms. TINKER. OIG's recommendations concur with GAO's, in that training and guidance are critical parts of prevention. But I would note that data and identifying risk areas is also critically important, so that we are training and providing guidance in the right places.

If even one individual had reported in one of the instances that I talked about in my oral testimony, we may have been able to prevent harm before it occurred.

Senator CARDIN. And I appreciate it. I would make one other observation. We should be reporting best practices of what facilities are doing that had mitigated abuse and share that information, so we put a spotlight on what is working to prevent abuse.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Warner?

Senator WARNER. Thank you, Mr. Chairman. Thank you for holding this hearing. I think we all share concerns about any reports of elder abuse.

In one of the earlier hearings we held on this subject, I raised some of the concerns I have as a former business guy about just some of the margins in the industry. If we look at Medicare in terms of skilled nursing facilities, with Medicare you have about an 11-percent margin, a pretty darned good margin. But when you blend in all the Medicaid patients, I think across the industry we are talking about margins of about half a percent. And I worry that some of the flaws we are seeing—before we even get to the report-

ing process and the ability to hire and retain quality individuals—may go down to the fact that the margins are so slim.

If I could do a second question, one of the concerns I have is about any other cuts toward Medicaid, which I think would translate through the whole industry, putting even more pressures on the nursing homes to kind of hire and retain good quality staff.

As I looked into this, some of the facilities in Virginia, some of the challenges we have seen about being able to do—and I know other members have raised this—reliable background checks, I know the HHS OIG reports have talked about some of the flaws in the existing background check process.

So we have been working with some of the providers in my State about looking at whether the provider should be granted access to the National Practitioner Data Bank. And I would like both of you to comment on that issue and whether you think access to that practitioner database might improve the overall screening process for nursing homes.

Ms. TINKER. We do not currently have any work looking at that link between the National Practitioner Data Bank and nursing homes. What I can tell you is that doing background checks and making sure you have as much information as possible about who you are doing business with is critically important to allow us to make sure that bad actors are not part of the program and are not in touch with and providing care to our vulnerable beneficiaries.

Senator WARNER. I would ask you guys to take a look, because wouldn't access to that National Practitioner Data Bank give you another review point, another checkpoint for homes that want to do the right kind of screening on the potential workforce?

Mr. DICKEN. Yes. Like my colleague, we have not specifically looked at the National Practitioner Data Bank, but we did hear that currently it can be very time-consuming to look at, and it would require looking at State-specific nursing aide registries or other licensing requirements. And so the ability to have more information that cuts across and coordinates across State information is certainly something of concern.

Senator WARNER. It would just seem to me that, obviously, when you get into data banks, you have to have appropriate privacy controls and not misuse, but if nursing homes had access to this information, I think personally it would actually improve the screening process and allow us to move forward.

I do want to raise the question, as well, about some of my concerns about the potential cuts on Medicaid funding. If we saw—and it seems to me just logical that if some of the proposals did either block-grant Medicaid or further cut Medicaid funding—if we are talking about homes that operate on a half-point margin—and again, for somebody with business experience, that is a pretty thin margin in almost any business—wouldn't those cuts in Medicaid funding put even further downward pressure on the nursing home facilities, which would then lead to lower-quality folks working in the nursing homes because, again, the financial pressures would constantly be pushed downward?

Do you both want to, in my last minute, go ahead and make a comment on that, related to Medicaid funding?

Mr. DICKEN. Certainly, staffing is a key cost for nursing homes, and so it is certainly also highly related to quality and preventing abuse. And so, while we have not specifically looked at the particular measures in that, that is a key issue to be focusing on as we look at this.

Ms. TINKER. I would agree with my colleague from GAO. We currently have ongoing work looking specifically at staffing levels and the importance and ramifications of that. We would be happy to come in, once our work is complete, and give you and your staff——

Senator WARNER. I would love to have that because, you know, I think we all see the bad examples, and we want to see some corrections. But we have got to make sure the businesses remain viable enough so they can actually afford to hire the appropriate people.

In the second panel, I am going to want to drill down a little bit on the ability to get CNAs into some of our, in some of the facilities in a better way.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Hassan?

Senator HASSAN. Well thank you, Mr. Chairman. And I want to thank both of the witnesses, not only for being here today but for your work.

And just before I ask my question, I did want to say that I wanted to note my strong opposition to the administration's decision last week to once again allow nursing homes to use forced arbitration agreements for patients in their care and their families. Nursing home residents should not be subjected to coercion that this new rule could allow, a coercion that would essentially force them into limiting their rights in order to access the care they need.

This is particularly true in light of the increasing instances of abuse reported by our witnesses today. Residents and their families should be allowed to pursue a full range of legal options against nursing homes that fail to prevent the kind of abuse and neglect we are talking about in this hearing. And I think it is very troubling that the administration is reversing a rule that we have now that just bans any kind of forced arbitration agreements between nursing homes and their residents, or the resident's family.

I did want to ask a question. Much of what I had on my list has been covered, so I think what I would like both of the witnesses to take from this hearing is that you have a lot of us who are very interested in working with you to make sure that, when it comes to the rating system that we have for nursing homes, we find a better way of making sure that that rating system reflects the true quality and alerts potential residents and their families to any history of abuse or neglect that nursing homes have.

But I did want to drill down on one more thing with you, Ms. Tinker. I found it concerning that, according to your report and your testimony, the Department of Health and Human Services does not require all incidents of potential abuse or neglect and related referrals to law enforcement to be recorded and tracked in the existing tracking system. Could you talk a little bit more about that, and any steps Congress might take to help ensure that the Department is appropriately tracking these incidents going forward?

Ms. TINKER. We did find that, in fact, those were not incidents that needed to be tracked and reported into the current database that CMS uses. And we made a recommendation to CMS that they change that particular requirement, and CMS concurred with us.

Senator HASSAN. So they concurred. And they can do that without any congressional action, is what you are telling us?

Ms. TINKER. That is my understanding.

Senator HASSAN. Okay. Well, thank you. I look forward to the second panel as well, and I yield the rest of my time.

The CHAIRMAN. Thank you. Senator Casey?

Senator CASEY. Thank you, Mr. Chairman. I want to commend Chairman Grassley and Ranking Member Wyden for having this hearing and for their work on this issue.

I think what I am about to say is true of other States. I know that in Pennsylvania and across the United States there are nursing homes that serve their residents well and treat them with dignity, care, and kindness—the dignity, care, and kindness they deserve. But it is outrageous, and that is an under-statement, to hear stories of abuse and neglect in nursing homes that do not live up to those high standards.

It is for this reason that I partnered with my Pennsylvania colleague, Senator Toomey, to shed light on poor-performing nursing homes. And I will get into the detail of those numbers. We launched an investigation into a Federal initiative which goes back a number of years, the Special Focus Facility Program, that targets these poor-performing homes. The names of nursing homes in this program are made public. But unbeknownst to families nationwide, there is a list of more than 400 additional nursing homes identified each month also needing urgent intervention.

So to be specific, we have made public, or the government has made public, participating facilities in this Special Focus Facility Program, about 88 facilities. The candidate list, that additional 400, approximately 400 homes, the candidate list was not made public until recently. So the participants, 88, add up to .6 percent of all nursing homes. The candidates, the 400 or so, add up to 2.5. Add them together, it is 3.1 percent of 15,700 facilities. So it is a low number by percentage, but when you consider what is happening in some of those 3.1 percent, it is a lot of problems.

Prior to our investigation, few had knowledge of this list, this longer list of 400 or so, and even a smaller circle knew the names of the facilities on it. Our investigation concluded with the release of the secret list, alongside a report that found a number of things.

Number one, a nursing home's participation in this oversight program for poor performers is not readily transparent or easily understood among would-be residents or their families. There is no information on Nursing Home Compare for explaining the reasons for a facility's participation in the program, the length of time it has been in the program, or whether it has improved.

Number two, candidates for the program receive no additional oversight.

Number three, several candidates' facilities possessed star ratings that were misleading. Approximately 48 percent of candidates had a quality rating of three stars or higher, and there were even 9 facilities that performed poorly enough to be candidates for the

program but received perfect staffing and quality ratings on Nursing Home Compare.

I ask unanimous consent, Mr. Chairman, that this report—and it is entitled "Families' and Residents' Right to Know: Uncovering Poor Care in America's Nursing Homes"—this report that Senator Toomey and I worked on, I ask consent that this report be made part of the record.

The CHAIRMAN. Without objection.

[The report appears in the appendix beginning on p. 47.]

Senator CASEY. Last month, Senator Toomey and I secured a commitment from the Centers for Medicare and Medicaid Services to make this previously undisclosed list of nursing homes public. Now that the administration has heeded our calls for greater transparency, we need to do more. Senator Toomey has agreed to work with me on legislation strengthening programming for nursing homes that consistently fail to meet the high standards we should expect of every facility.

I am committed, and I know others are, to finding solutions to lift up, lift up nursing homes that are doing right by their residents and make sure that those facilities that are falling short are subjected to needed oversight. I look forward to working with Senators Grassley and Wyden on this. I also remain concerned about other areas of transparency. We know that, through the Affordable Care Act, Congress recognized cost reporting on Medicaid dollars received by nursing homes as critically important.

So, Mr. Dicken, in the remaining seconds I have, why is the accessibility of cost reporting and spending information so important? That is question one. Question two: what has CMS done to follow up on your agency's recommendations to make this information more accessible and reliable?

Mr. DICKEN. Thank you. In a 2016 report, GAO did look at the requirement that CMS make cost information available. They have reported raw data on their website, but this information is really important for transparency of information on expenditures, for the reliability of it, and really for public confidence in the financial data.

We made recommendations to improve the accessibility of that cost data, as well as the accuracy and the completeness. CMS did agree with our recommendation to improve the accessibility, but unfortunately has not yet taken steps on accuracy, as more recently indicated, because they believe that the cost of doing so would outweigh the benefits.

They did not agree with our recommendations on improving the accuracy and completeness. So GAO maintains both recommendations have not yet been addressed by CMS.

Senator CASEY. Thanks very much. And, Ms. Tinker, we are grateful you are here as well. I will send you a question for the record. Thank you.

The CHAIRMAN. Thank you, Senator Casey. Senator Brown?

Senator BROWN. Thanks, Mr. chairman. I appreciate that. Ms. Tinker, thank you for joining us. Both of you, thank you for joining us.

In 2018, OIG issued a report titled "Solutions to Reduce Fraud, Waste, and Abuse in HHS Programs" with OIG's top recommenda-

tions. One of the top 25 unimplemented recommendations relates to skilled nursing facilities. Let me quote it briefly: "CMS should analyze the potential impacts of counting time spent as an outpatient toward the 3-night requirement for SNF services so that beneficiaries receiving similar hospital care have similar access to these services."

Would you briefly elaborate on those recommendations, please?

Ms. TINKER. I am sorry, I am not familiar enough with that particular piece of work to elaborate on it, but we would be happy to come and have our experts brief you and your staff.

Senator BROWN. Okay; I appreciate that. In terms of, I mean I think you know, I assume you know the issue enough to know the importance of our legislation improving access to Medicare coverage in time of sickness so patients and their families should not have to worry about whether or not Medicare will reimburse their care based on a billing technicality. So I am hopeful. And I ask any of my colleagues listening today to join us in that legislation.

Let me ask a question to both of you. The list of GAO reports and OIG reports on nursing home neglect and abuse goes back more than 20 years. In my State it has gone back even further than that, investigations from State government on nursing home abuses. It is not a new problem. It is an old one we have not solved. It is an old one that is about to get worse as more baby boomers age and require care in these facilities. What will it take to make the system safe? Is it not time to do something different from what we have done in the past?

I will start with you, Mr. Dicken, and then Ms. Tinker.

Mr. DICKEN. You are right that we have had, in our case, more than 20 years of reports, not just on abuse but overall concerns about oversight of care, neglect, and poor care in some nursing homes. And so we have seen changes have been made. There have certainly been efforts. There is more information available than there was 20 years ago.

But when we look at trends over time, we see really mixed results, that there have been increases recently in complaints about nursing homes. Other clinical indicators have been focused on preventing falls. Antipsychotics and other things like that have improved.

So there are changes. There is more information, but unfortunately some of the same systemic issues that we have seen over the last 20 years remain and require really continued vigilance by this committee that has been active in this issue, by CMS, and by the States.

Senator BROWN. And, Ms. Tinker, as you answer the same question, would you also roll into your answer any differences you see over the years as you have studied these facilities and how they are managed between for-profit facilities and not-for-profit facilities? And maybe lead with that part of the answer, and then if you want to comment on Mr. Dicken's thoughts.

Ms. TINKER. We have not examined the differences between for-profit and nonprofit facilities. When we do our work, we are really agnostics to that because we are looking, regardless of where it occurs.

Senator BROWN. Should we be agnostic on that?

Ms. TINKER. Oh, I think, in looking at abuse and neglect, we need to look for it anywhere that it happens, and in——

Senator BROWN. But do we not need an analysis the next level down if it is more serious in for-profits than not-for-profits? Does that not suggest a different policy response?

Ms. TINKER. Certainly that is possible. But we do not have work that looks specifically at that difference. And without that, it would be difficult for me to comment on what that might look like.

What we know is that, across the board, abuse and neglect occur, and we do not have all of the necessary safeguards in place.

Like Mr. Dicken said, we have seen changes over time in terms of use of antipsychotics in inappropriate ways, and that has definitely improved over time. However, there is obviously more to be done.

Again, one of the things I think that is very important is that, over time, our ability to both have the appropriate data available and also then to perform sophisticated data analytics so that we can identify risk areas has improved drastically in the last 20 years.

We now have better ability to utilize data to identify risk areas and then take the appropriate steps to correct them. However, as we continue to do this and issue reports talking about how we have utilized that data—including the guide that we issued today, that we hope will empower CMS and State providers to do the same kind of data analytics that we have performed—we continue to hear from CMS that they do not agree with implementing that particular recommendation.

Senator BROWN. Thank you. I assume it would not be difficult to go to the next step, taking the analyses that you have done on abuses in dozens and dozens of nursing homes, if asked by Congress with GAO and the Inspector General, to be able to look and see if this group is for-profit, this group is not-for-profit. Maybe one is worse than the other, or maybe not. Correct?

Ms. TINKER. We would definitely be willing to talk with you and your staff about potential work.

Senator BROWN. Has GAO listed the difference between for-profit and nonprofit?

Mr. DICKEN. So we do provide information in our report on different characteristics of homes, including profit status. We did find that for-profit nursing homes were about two-thirds of the nursing homes and were about 78 percent of the homes with 2 or more years where we found deficiencies and about 73 percent of homes with a deficiency in 1 of the 5 years we looked at.

Senator BROWN. That is not insignificant, a statistically insignificant number.

Mr. DICKEN. So we did—you know, these are representative from looking at 5 years of data. What occurred during those 5 years for abuse deficiencies was somewhat higher. We note that there are a lot of factors, that the mix of patients that may be in homes by different status and other things were also related. So there are a number of factors, and we did not look at those across multiple factors that may affect them.

Senator BROWN. Thank you.

The CHAIRMAN. Senator Cortez Masto?

Senator CORTEZ MASTO. Thank you. I thank you both. I also want to thank Chairman Grassley for holding the hearing on this important subject.

Ms. Tinker, let me start with you. In your testimony you stated that when Medicare beneficiaries residing in nursing homes are admitted to the emergency room, 20 percent of the time that visit is the result of abuse or neglect on the part of the beneficiary's nursing home.

It is clearly a problem. Let me ask you this. We have heard from stakeholders that this trend is improving, that skilled nursing facility quality is improving. Would you agree with that?

Ms. TINKER. We looked at a snapshot in time in 2016 when we pulled that data, and so we did not look at trends overall in terms of whether the nursing facility quality was improving. In another report that we did, we did look at a larger snapshot, and we did find a slight increase that occurred in terms of the number of deficiencies that occurred in 2017.

So again, it is a small number overall, but we do have concerns about abuse and neglect increasing.

Senator CORTEZ MASTO. So how do we ensure that we are tracking that over time instead of having to do these snapshots? Is there a way that we can implement reporting, tracking, data analytics to verify that this is ongoing and we can look at it at any time, the public can look at it, the family members can look at it to see what is going on? Is there a way to do that?

Ms. TINKER. Well certainly, that is very aligned with the recommendation that we made to CMS to look at overarching Medicare data for signs of potential abuse or neglect and to utilize that data to identify risk areas. And we will continue to recommend that.

Senator CORTEZ MASTO. But it has not been implemented yet?

Ms. TINKER. No. And in fact, CMS did not concur with that recommendation.

Senator CORTEZ MASTO. Okay; that is disappointing. Let me ask you this. In your written testimony, the second statement you make is that CMS, States, and providers must ensure that potential abuse and neglect is recorded to enable oversight and prevention. "Reported" to whom?

Ms. TINKER. So reporting requirements vary. So we are talking about reporting to State survey agencies so that they can actually investigate and look at what happened. We are also talking about, where suspected criminal things have occurred, reporting to law enforcement.

Senator CORTEZ MASTO. So talk a little bit about law enforcement, because this was my concern that I saw in your report: that there was not timely reporting to law enforcement when there was concern that criminal activity was occurring.

Ms. TINKER. Absolutely. So when you talked about our statistic of one in five potential abuse or neglect cases occurring, out of those one in five, 84 percent of them were not actually reported as appropriate, based on our finding.

Senator CORTEZ MASTO. And why is that a problem?

Ms. TINKER. That is a problem because, when law enforcement and appropriate reporting entities do not have the information,

they cannot take the steps to investigate and take appropriate corrective actions about abuse and neglect.

Senator CORTEZ MASTO. And let me bring it down to a level even closer to that, as somebody who was a former prosecutor and Attorney General: you want to preserve the evidence.

Ms. TINKER. Absolutely.

Senator CORTEZ MASTO. You want to know immediately if there is potential criminal activity. You file that so that you can preserve the evidence, put the facts together, learn, do an investigation. And if there is a delay in that, then there is a delay in holding somebody accountable based on the facts and evidence. You lose that evidence. Is that correct?

Ms. TINKER. That is absolutely a possibility.

Senator CORTEZ MASTO. And how long are we talking the delay has occurred before any type of referral to law enforcement?

Ms. TINKER. In that specific report, we found no evidence that any reporting had occurred at all in 84 percent of the cases.

Senator CORTEZ MASTO. And that to me is very disturbing. In particular, as somebody who had oversight over the Medicaid Fraud Control Units in the State of Nevada, I think this to me is an area that should be immediately referred, whether you think it is happening or not, and law enforcement will make that determination. But it should be immediately referred. And we are falling short in that sense.

Let me ask you, Mr. Dicken: you state in your testimony that you found that substantiated reports of abuse in nursing homes increased from 2013 to 2017, with the largest increase in the most severe types of abuses. To what do you attribute that trend?

Mr. DICKEN. Yes, and we did see that doubling overall, as well as concerning that those abuses, the portions of those abuses that caused actual harm or put residents in immediate jeopardy, were a larger share. You know, we looked at factors that could complicate this. We do not specifically have reasons why it has doubled in 2017 from 2013, but we do know that there are things such as the mix of residents, staffing issues, challenges that have been cited as reasons why abuse is challenging. Those existed in 2013 and 2017, so I am not saying that is why they increased, but certainly more awareness of this and other things may be contributing.

We do know that, while CMS has made some changes more recently in their inspection process, that was constant during the 5-year period we looked at.

Senator CORTEZ MASTO. Thank you. Thank you, both. I appreciate it.

The CHAIRMAN. All right. That concludes our first panel. Thank you for your testimony today, and we will now seat the second panel.

[Pause.]

Senator DAINES [presiding]. All right, welcome. First I want to extend a warm welcome to Bob Blancato of the Elder Justice Coalition. As its national coordinator, Bob works with hundreds of organizations dedicated to fighting elder abuse. Chairman Grassley has known and respected Bob for many years, starting with the 17-year tenure on the staff of the House Select Committee on Aging. Bob

has been a member of the board of the AARP and the National Council on Aging. He has also served as State president of AARP Virginia. Bob has participated in several White House conferences on aging. In 2015, he was appointed to the CMS Advisory Panel on Outreach and Education. I commend Secretary Azar for his wisdom in adding Bob to the National Advisory Committee on Rural Health.

Our next witness, Mark Parkinson, is the former Governor and Lt. Governor of Kansas. He now leads the trade association representing most of the Nation's nursing homes, group homes, and assisted living facilities. He also once owned a nursing home. Welcome, Governor Parkinson.

Our final witness is Lori Smetanka. Ms. Smetanka is executive director of the National Consumer Voice for Quality Long-Term Care. Her nonprofit represents other advocates, long-term care ombudsmen, and residents of nursing homes. Previously Lori spent a dozen years as director of the National Long-Term Care Ombudsman Resource Center.

All right, we will start with Mr. Blancato. Please proceed.

STATEMENT OF ROBERT B. BLANCATO, NATIONAL COORDINATOR, ELDER JUSTICE COALITION, WASHINGTON, DC

Mr. BLANCATO. Thank you, Mr. Chairman. It is an honor to be here this morning, Chairman Grassley. I want to thank him for his enduring commitment and leadership on issues impacting older adults for more than 40 years, and Senator Wyden for his distinguished record of leadership and advocacy for older adults.

Thanks also to Evelyn Fortier and John Pias with the chairman, and David Berick and Rebecca Nathanson with Senator Wyden, for their help.

The nonpartisan Elder Justice Coalition for the past 16 years has been the national voice promoting elder justice by advocating for Federal policies to prevent elder abuse.

Let me start with a question, or our plea: what are we waiting for? Financial elder abuse costs its victims more than $3 billion a year and has been labeled the crime of the 21st century. More than one in 10 older adults is a victim of abuse. Elder abuse victims are four times more likely to be admitted to nursing homes and three times as likely to hospitals.

What are we waiting for? The average victim of elder abuse is an older woman living alone between 75 and 80. Today, 46 percent of women over 75 live alone, and that number is rising. And new and even more disturbing, is the growing link between elder abuse and the misuse of opioids. Our coalition working with Adult Protective Services in four States found a double-digit increase in elder abuse cases tied to opioid abuse.

This is a national emergency. But today it is about renewing and expanding a commitment from almost 10 years ago when the first Elder Justice Act became law. A new bill can be a catalyst for taking the kind of action we need to.

There are two key dimensions to the Federal role which we need to affirm. First, since less than 5 percent of older adults live in nursing homes, we need to invest money into elder abuse prevention programs at the State and local level to find better solutions.

Second, the Federal role is to pass but, more importantly, enforce laws so Federal funds are not an enabler of elder abuse occurring either in the community or in long-term care facilities.

We urge you to keep the first core elements of the Elder Justice Act in your new bill: dedicated funding for Adult Protective Services, enhanced training and support for the Long-Term Care Ombudsman programs, and providing grants for the establishment of elder abuse forensic centers.

The main features of the Elder Justice Act were to achieve dedicated and adequate funding for Adult Protective Services. Neither has been accomplished. APS caseloads across the country are increasing, according to the national service. There was a 15-percent increase in reported cases between 2017 and 2018 nationally, with over 100-percent increases in States like New York and Minnesota over the past 7 years. And most recently, we have new cases tied to opioid abuse in a number of States.

But their resources are declining. APS needs an adequate authorization of funds. First, let us make APS a priority in any future set-aside of funds under the Victims of Crime Act, because APS, like VOCA funds, go to direct assistance services for crime victims. So please consider this in the upcoming legislation.

With the ombudsman program, let a new bill fund grants for better training to address resident complaints about abuse and neglect, and grants for training of the nursing home workforce, which would benefit both residents and the ombudsmen.

Also consider having some funding for ombudsmen to be provided through the Medicare trust fund, as called for by the Leadership Council on Aging organizations. Let us keep the good work of the Elder Justice Coordinating Council going. Fourteen different agencies are effectively coordinating resources to help tackle elder abuse. And yes, it is time for an advisory board on elder abuse and for forensic centers. Too many older adults end up in emergency rooms with physical injuries. Some might be fall-related, some might be elder abuse. Not enough emergency departments know how to distinguish. Forensic centers can help.

We look forward to improving Nursing Home Compare. Mr. Chairman, I was at your hearing when Ms. Blank testified about her mother dying from the neglect in a five-star facility. That went beyond the pale.

The GAO report validated what nursing home residents and advocates have said for a long time. Much of the abuse and neglect and exploitation that take place is severely under-reported. Better oversight by CMS is so needed.

Resident safety must be the top priority. We need to be more aggressive about tying conditions of participation to ensuring that facilities are free from abuse and neglect. We must prevent future horror stories in nursing homes tied to natural disasters. We hope you will address this in your bill, especially developing and implementing emergency response plans.

Mr. Chairman, we know of your pioneering work in combating social media abuse in long-term care facilities and look forward to how this can be addressed in your new bill. We commend the work, and we hope you will continue to update the authority to promote

criminal background checks of perspective employees in long-term care facilities.

Since only six States participated and submitted the right data to make the criminal background checks the last time, and only 3 percent of people were qualified, we must do better.

I commend Senator Wyden for his work on improvements in the next version of this program, and we look forward to working on this.

I want to note, there are fine nursing homes staffed by high-quality staff. I know this. My mother was in one. We should not stigmatize all nursing homes. The focus is on those facilities that do not meet the standards, but also on lax Federal enforcement of laws enacted to prevent abuse. We suffer from an intergenerational cycle of abuse: child abuse to domestic violence to elder abuse. The Federal response to child abuse goes back more than 40 years, domestic violence, more than 25, and reports are decreasing in both. But we still lag on elder abuse, and failure to improve can be one of the worse examples of agism in public policy.

Thank you, Mr. Chairman.

The CHAIRMAN. I am sorry I was not here to introduce you. I would have romanced about the years we started out on the House Committee on Aging. You were a staff person, and I was a freshman Congressman and an original member of the first year of that committee and served there while I was in the Congress. So I am sorry I was not here. I was down the hall at Judiciary.

Mr. BLANCATO. It is great to be here. Thank you.

[The prepared statement of Mr. Blancato appears in the appendix.]

The CHAIRMAN. Governor Parkinson?

STATEMENT OF HON. MARK PARKINSON, PRESIDENT AND CHIEF EXECUTIVE OFFICER, AMERICAN HEALTH CARE ASSOCIATION, WASHINGTON, DC

Governor PARKINSON. Thank you, Mr. Chairman. I am here this morning to let you know that we want to be your partner in addressing these issues. I am the president of the American Health Care Association. AHCA represents over 10,000 of the 15,000 nursing homes in the country, and we really appreciate your attention on these matters.

My background is public service, but my life's work has been long-term care. My wife and I built and owned nursing homes in Kansas, and we worked inside of them. We did not own them passively; we worked side by side with our CNAs for many years. So we know first-hand how important this work is, and how difficult it is, but it is incredibly important.

The people who live in our buildings are terrific people, and they deserve exceptional care. The stories that we have heard today are completely unacceptable. There really is no level of abuse and neglect that should be tolerated—none at all. Our position is that any case of abuse and neglect is really one case too many.

But we do want to be your partner. When I interviewed for this job back in 2010, I was pleased that the leadership of the Association told us that they wanted to head in a new direction. Providers

had been seen as part of the problem on quality and not the solution, and they wanted to change that.

And so I enthusiastically took this position in 2011, and we got to work. We hired David Gifford, who at the time was the Secretary of Health in Rhode Island. We developed a quality division at AHCA. It is now our largest division. And we decided that we wanted to try to improve quality across the country, the metrics across the country. It is a hard thing to do.

We knew that we would need new solutions to do it. And so we did that. We sat down with CMS and we agreed to some specific quality measures that we agreed to improve by a specific amount at a specific date. We doubled down on our quality award program, and we started bringing quality solutions to the Hill, like our value-based purchase program that we voluntarily brought to the Hill and ultimately became law.

I am happy to tell you that these approaches have worked. Senator, when you look at the clinical outcomes which have been measured in great depth for many years, between 2011 and now we have had significant improvements in re-hospitalizations and decrease in the use of anti-psychotics, in reports of pain, in reports of urinary tract infections, various other things. We have seen improvement.

Today's report, which of course we have not had a chance to review yet—it was just released today—is obviously disturbing in indicating an increase in abuse and neglect. But we will apply the same rigor that we have to the other problems that we faced in the industry, and I believe that we can get the same kind of results.

I am proud of the results that we have achieved, but I do not tell you about them because I am proud, I tell you about them because I think they provide an important guidepost to how we can achieve additional improvement in the future.

We have to work together. We have to collaborate. And there are things that can be done in payment that also incentivize outcomes and that have been very successful.

Again, we look forward to reviewing the report in depth and coming up with specific suggestions, but there are some things that we would encourage you to consider adding to the Elder Justice Act that we think might help solve this problem immediately.

First, we do need a better background check system. Every State does have a background check for CNAs, but they only reveal the bad actors from that State. We do not have access to the national database that would allow us to see when someone has moved from State to State, and that is a big cause of the problem.

Secondly, we think that you should add patient satisfaction to Nursing Home Compare. When we want to go out to a restaurant, or look at a hotel, we go to the Internet and we look at reviews. You cannot do that on Nursing Home Compare because patient satisfaction is not there. There are a lot of clinical indications, and that is really good to have, but what people really need to know is from prior patients and prior family members, is this a good place or a bad place? And we would really encourage CMS to add it.

Thirdly, we need help with workers. There is just a massive shortage of workers, and if we do not fix that problem, a lot of these other things are going to be difficult to address.

And finally, reimbursement does come into this. Two-thirds of the people who live in nursing homes are funded by Medicaid. There is a dramatic under-funding of Medicaid. As was indicated earlier, the overall margin in nursing homes is less than one-half of 1 percent. Hundreds of buildings went bankrupt last year. It is very difficult to bring people along on our quality journey when they are having to be so focused on whether or not they can keep their doors open or not.

So again, we greatly applaud these efforts. We look forward to collaborating with you on solutions. We believe that, as challenging as these problems are, and as horrible as some of these stories have been, we can keep this from happening in the future. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Governor. And you said you wanted to work with us. So consider my door open to considering your points of view.

Governor PARKINSON. Terrific. Thank you.

[The prepared statement of Governor Parkinson appears in the appendix.]

The CHAIRMAN. Ms. Smetanka?

STATEMENT OF LORI SMETANKA, EXECUTIVE DIRECTOR, NATIONAL CONSUMER VOICE FOR QUALITY LONG-TERM CARE, WASHINGTON, DC

Ms. SMETANKA. Thank you, Chairman Grassley, Ranking Member Wyden, and members of the committee. Thank you for holding this important hearing.

Under Federal law, each nursing home resident is to receive care and services that help attain and maintain their highest possible physical, mental, and psychosocial well-being. However, reports such as we have been hearing today continue to indicate that more must be done to protect residents from abuse and ensure quality care and life.

We can do better, and I offer recommendations that we believe will make a difference for residents.

First, we need to require standards for a sufficient workforce. The relationship between staffing levels and quality of care is well-documented. When there is not enough staff, residents suffer. Lack of staff, when combined with stress and burnout, are factors that can lead to abuse and neglect. A recent analysis of staffing data shows that the majority of days, nursing home staffing levels are below what CMS expects. Nursing homes fail to properly staff registered nurses and reduce staffing levels on evenings and weekends.

Federal standards in this area are lacking, and thus we call on Congress to establish and enforce minimum requirements for numbers of direct-care staff, including the presence of registered nurses on-site 24 hours per day.

Secondly, we should establish standards and oversight for ownership and operation of facilities. Significant changes in the ownership and management of nursing homes have seen an increase in

corporate facilities and private equity ownership. Many of the decisions that affect care, including budgets and staffing levels, are made at the corporate level, yet oversight is limited to individual facilities.

It is not unusual, however, to see patterns of poor care across facilities owned by the same companies. In addition, no meaningful Federal criteria exist when approving Medicare and Medicaid certification for evaluating financial or management capacity to successfully operate a facility. CMS largely relies on State licensure processes, many of which are also lacking.

The collapse of Skyline Healthcare in the spring of 2018 is a tragic example of the impact on residents, workers, and systems when proper vetting and oversight of providers does not occur.

Congress should pass legislation to hold corporations accountable when patterns of poor care are identified across their facilities, establish minimum criteria for approving and disapproving Medicare and Medicaid certification, and enact a medical loss ratio that limits administrative costs and profits.

Thirdly, we suggest implementing, enforcing, and preventing the rollback of standards. Maintaining a strong oversight and enforcement system is key in preventing and addressing abuse and neglect, yet problems go unsubstantiated or under-cited, and changes in CMS policy have resulted in a nearly 30-percent reduction in the average fine.

Strong resident-focused regulatory standards are critical to protecting rights and preventing poor care. The issuance last week of CMS's final rules allowing predispute arbitration and proposing rollbacks to the current nursing home rules are steps in the wrong direction.

Instead, we recommend that Congress incorporate into statute important provisions from the 2016 nursing facility regulation, such as the requirement for an annual facility assessment and a ban on predispute arbitration, and also, expand and strengthen requirements for the Special Focus Facility program, including rules for graduating from the program, and penalties.

We additionally recommend that Congress enact legislation that requires residents and their designated agents be informed of the possible risks and side effects of antipsychotic drugs.

Fourth, we suggest increasing transparency of information. Because choosing a long-term care facility is a decision that is often made quickly and in a time of stress, the information on Nursing Home Compare must be reliable, comprehensive, and easily understandable.

CMS has made improvements in the information, yet additional steps can be taken, such as eliminating the inclusion of self-reported data in the ratings calculations and adding an icon for facilities with abuse deficiencies.

And lastly, we suggest strengthening and funding elder justice provisions. The need for action to strengthen elder justice reporting, prevention, and response continues. Better screening of individuals seeking to work in a long-term care facility through a Federal background check system is necessary to screen out those with criminal records who pose a danger to residents.

Congress should amend the National Background Check Program and require all States to participate in and fulfill the requirements of the program. Further, reauthorization and full implementation of the Elder Justice Act, including requirements to report suspicions of crime, and funding for the ombudsman program, are important and impactful steps that Congress can take.

In conclusion, increased prevalence of physical and cognitive impairments make nursing facility residents more at risk of abuse and neglect. Failure to prevent or report abuse is unacceptable. It prolongs the victimization and suffering of those being abused and puts other residents at risk as well.

In this time of increased attention on resident abuse and neglect, we need to take stronger action to protect residents, not go backwards. We stand ready to work with the committee on these issues. Thank you.

[The prepared statement of Ms. Smetanka appears in the appendix.]

The CHAIRMAN. Thank you. Since there is a vote going on, I thought I would ask one question and then, if you folks can ask one question, we will shut it down then, because I do not think we are going to get anybody back here this afternoon.

My one question goes to Bob. It is about the Elder Justice Coordinating Council. I think it plays an important role in ensuring information sharing by Federal agencies. Should its role remain the same? Or should Congress charge it with new and different responsibilities?

And then I will put the rest of my questions in the record.

[The questions appear in the appendix.]

Mr. BLANCATO. Thank you, Mr. Chairman. We are big fans of the Elder Justice Coordinating Council. We think it was one of the great accomplishments of the Elder Justice Act. You have 14 different Federal agencies aligning to work on many fronts that deal with the multi-faceted issue of elder abuse, from cracking down on robocalls, which the DOJ and FCC and FTC are doing, to coordinating the use of volunteers for take-back drug days, like Senior Corps and the Administration for Community Living. But we should see, are there any Federal agencies missing? We should look at that so we can suggest a possible modification of their roles so they can offer input on future elder justice legislation.

We suggest they might want to call a summit with our coalition and other groups, State and local coalitions, and multidisciplinary groups operating in local areas. And I also say they should take their meetings out of Washington. They need to go on the road with the Elder Justice Coordinating Council, because most of the activity is outside of Washington. So those are my recommendations.

But we urge you to go forward and continue it.

The CHAIRMAN. I am going to leave, and I am going to call on Senator Hassan, and then Senator Cortez Masto. And, Senator Cortez Masto, you will be the last one, so shut it down. And I want to say "thank you" for your participation.

Senator HASSAN. Well thank you, Mr. Chair, for holding this hearing with these two excellent panels, and thank you all for your

testimony, and I am sorry that we have a vote scheduled right smack in the middle of it.

I will follow up with all of you about what we can do to help with staffing and retention, recruitment and retention, because it is something I hear about all the time. But I wanted, Ms. Smetanka, to focus with you on an issue of particular concern for me that relates to individuals who experience complex disabilities, who are living within nursing home settings.

While the ultimate goal is to move more individuals who experience disabilities into their communities and homes, the reality is that many individuals still live in institutional settings, often at nursing homes that can meet their complex care needs.

In addition, aging individuals who experience disabilities face additional health complexities and are particularly vulnerable to the kinds of abuse and neglect that we have discussed here, particularly in the earlier panel. For example, these individuals may be unable to communicate to report instances of abuse or neglect, or struggle to advocate for their best interests when abuse or neglect occurs.

Time and again, instances of abuse and neglect are reported that disproportionately impact individuals with disabilities.

So, Ms. Smetanka, as we work toward prevention efforts, do you have any suggestions as to how we can best protect this unique population from abuse and neglect?

Ms. SMETANKA. Thank you, Senator, for that question. We agree with you that this population needs specific protections. And so, having a strong Long-Term Care Ombudsman Program is certainly critical for protecting the whole population that is living in long-term care facilities. Proper funding so that ombudsmen can be present and onsite as much as possible to interact with residents and respond to concerns and complaints that they have—and also to prevent abuse from occurring—is really critical.

But I think also having enough staff on hand to ensure that these residents are receiving proper care and services is absolutely necessary. If enough staff are not on hand, not only does it put stressors on everyone else working in the facility, but it also affects the care that they are receiving, and it ensures that there are not enough eyes looking at what is happening in a facility if people are not able to communicate their own needs and what is happening to them themselves.

Senator HASSAN. Well, thank you very much. And I will follow up with the other two panelists as well on this issue. But in the interest of time, I yield the rest of my time to Senator Cortez Masto.

Senator CORTEZ MASTO [presiding]. Thank you, Senator Hassan.

Thank you, all three of you, for being here. And I so appreciate the recommendations. I know there is still time to digest the report that came out, but I appreciate you coming forward.

So, Governor, let me direct my question to you. And first of all, I thank you for the Association being here. I also want to say I have worked in the past with so many associations, and I think there is an important role to play. There are good players, and we have heard that. There are good facilities out there. But there are also bad ones, and we need to weed them out. And I have always

found that the associations are always helpful in doing just that. And I think that is what we see here today.

But let me ask you this. There is some common ground we had on recommendations, but one of them that I heard was to require standards when it comes to staffing.

I am curious, Governor, what you think about that and the impact it would have.

Governor PARKINSON. I have worked thousands of shifts on the floor and, you know, there are times when you can have a fantastic CNA and accomplish more than when you have two or three who are just not up to snuff. In the aggregate, it is always good to have more people than to have less. But the industry has actually done a pretty good job of it. Our average number of hours per each resident right now is at 3.87, which is actually considered to be pretty high. There are some people who are at the very far end, I think, as reflected by the testimony today, who would want a requirement of about 4.1 hours per resident per day.

There has been an analysis of that. It would cost about $6 billion, and I think that is the reason that CMS and Congress have backed off. Our position has been that if there is a mandatory staffing requirement that would be paid for, we are all for it. But if it is not paid for, there is just no practical way to do it.

I will also tell you there is an anomaly with the current economy. It is so hard to get people in a number of States that have their own State staffing requirements. They have had to back off just because it has really been challenging.

But in the aggregate, we would agree that having more staff is certainly better than having fewer. It just becomes an issue as to what are our priorities as a country to pay for these services. And so far, our priorities have not been up to snuff.

Senator CORTEZ MASTO. Thank you. Does anybody have a response to that?

Ms. SMETANKA. I would just argue that having more staff on hand has been shown to improve quality of care. That is what the data does show. And I do think we need to look at how the money is currently being spent by long-term care facilities. And so we would encourage Congress to evaluate and audit, and require auditing of the data and how the money is spent that long-term care facilities receive, and how it is used, so that we can really assess what additional funds are needed to bring more staff into these places.

Senator CORTEZ MASTO. Thank you. Let me say "thanks" to everyone who participated in today's hearing. Let me close by saying that any written questions members may have for the record need to be submitted by August 6th.

And with that, this hearing is adjourned. Thank you.

[Whereupon, at 12:35 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF ROBERT B. BLANCATO, NATIONAL COORDINATOR, ELDER JUSTICE COALITION

Chairman Grassley, Ranking Member Wyden, it is an honor to be invited to testify this morning. We commend Chairman Grassley and Ranking Member Wyden for this hearing and the important topics around elder justice it will address. I know with respect to Chairman Grassley it is just one more example of a commitment to issues related to older adults that spans more than 40 years. Ending elder abuse, neglect, and exploitation is a bipartisan issue and goal.

The Elder Justice Coalition is a non-partisan 3,000-member group dedicated to advancing elder justice policy at the Federal level, whether through passage and implementation of legislation or through regulatory action. We were established in 2003 at the time the first Elder Justice Act was introduced. Many of our members provide direct services to elder abuse victims, such as the National Adult Protective Services Association and the National Association of State Long-Term Care Ombudsmen, or provide public outreach and advocacy on elder abuse, such as the American Society on Aging's elder abuse advocacy focus and online elder abuse gerontology course.

ELDER ABUSE: THE NUMBERS

We all know the sad numbers. Here are just a few. Justice Department figures say one in ten older adults are victims of elder abuse.[1] We also know from reports that victims of financial elder abuse lose at least $3 billion a year, with other reports suggesting dramatically higher losses.[2] The FBI reports that in 2017 alone almost 50,000 people over 60 lost a total of $342.5 million to Internet scams.[3]

According to the Elder Justice Roadmap report published by the Departments of Justice (DOJ) and Health and Human Services (HHS), elder abuse victims are four times more likely to be admitted to nursing homes[4] and three times more likely to be admitted to hospitals.[5] Residents of understaffed nursing homes are 22 percent more likely to be admitted to hospitals due to neglect.[6]

This same Federal report noted that many elder abuse victims have organic conditions such as dementia, brain injuries and other factors that lead to diminished or limited cognitive capacity. They are more susceptible to abuse, neglect and financial exploitation.

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[1] *https://www.justice.gov/elderjustice.*

[2] *https://www.sec.gov/files/elder-financial-exploitation.pdf.*

[3] *https://pdf.ic3.gov/2017_IC3Report.pdf.*

[4] Lachs, M., Williams, C.S., O'Brien, S., and Pillemer, K. (2002). "Adult Protective Service use and nursing home placement." *The Gerontologist,* 42(6), 734–739 (pp. 736–737).

[5] Dong, X.Q., and Simon, M.A. (2013). "Elder abuse as a risk factor for hospitalization in older persons." *JAMA Internal Medicine,* 173(10), 911–917.

[6] Centers for Medicare and Medicaid Services. (2001). "Appropriateness of Minimum Nurse Staff Ratios in Nursing Homes," Phase II Final Report. Baltimore, MD: Author (pp. 1–7).

Add one other sad reality—research says the average victim of elder abuse is an older woman living alone between 75 and 80.[7] According to the Census Bureau, today more than 46 percent of all women over 75 now live alone.[8]

Elder abuse is non-discriminatory. It claims nameless victims and big names too like Mickey Rooney, Brooke Astor, Stan Lee, and Casey Kasem.

Elder abuse is current—consider these headlines just from the past few days:

- [California] senior facility worker charged with identity theft, elder abuse.[9]
- Eight charged since March creation of [Michigan] Elder Abuse Task Force, Attorney General says.[10]
- Powder Springs, [Georgia] man convicted of elder neglect in death of 91-year-old.[11]
- [California] massage therapist suspected of raping a 77-year-old and sexually assaulting clients.[12]

THE ELDER JUSTICE ACT

Early next year, we will observe the tenth anniversary of the signing into law of the Elder Justice Act (EJA). Many of the members on this committee were supporters of this bipartisan bill. It was a landmark law at the time and its benefits can be seen in the following:

- It included a first-time definition of elder justice in Federal law, unifying statutes with undefined references to "elder abuse" and "elder justice."
- A total of $46 million has been appropriated by Congress for activities previously never funded for elder justice, including the National Adult Maltreatment Reporting System, or NAMRS; Elder Justice Innovation Grants; and a first-time Federal home for Adult Protective Services.
- The Elder Justice Coordinating Council's formation and work in developing more coordination and initiatives at the Federal level on elder abuse prevention.

Our Coalition calls for five core features of the Elder Justice Act in a new Elder Justice Reform Act:

- Dedicated funding for Adult Protective Services (APS);
- Strengthening the Long-Term Care Ombudsman Program;
- Continuing the important work of the Elder Justice Coordinating Council;
- Authority for an Advisory Board on Elder Abuse, Neglect, and Exploitation; and
- Funding for elder abuse forensic centers.

Let me elaborate on each of these.

Adult Protective Services

Dedicated funding for APS was the centerpiece of the original Elder Justice Act. It came about because APS is the only nationwide civil system authorized under State law to investigate reports of elder abuse, and State and local funding is too limited to support the demands upon APS. While the majority of States use some portion of their Social Services Block Grant allocation to provide funds for Adult Protective Services, it is far too inadequate. Moreover, the EJA provisions for APS provide the foundation for improving consistency in services between States, as we have done with child protective services.

The reality is that less than 5 percent of older adults live in nursing homes. Elder abuse prevention, like so many other services, is a community-based issue. We absolutely need to provide APS with adequate funding to do their work in investigating, treating and preventing elder abuse. We have failed to accomplish this to date.

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[7] *http://www.newhopeforwomen.org/elder-abuse.*

[8] *https://www.pewsocialtrends.org/2016/02/18/1-gender-gap-in-share-of-older-adults-living-alone-narrows/.*

[9] *https://sfbay.ca/2019/07/18/senior-facility-worker-charged-with-identity-theft-elder-abuse/.*

[10] *https://www.mcknightsseniorliving.com/home/news/eight-charged-since-march-creation-of-elder-abuse-task-force-attorney-general-says/.*

[11] *https://www.mdjonline.com/news/powder-springs-man-convicted-of-elder-neglect-in-death-of/article_62586024-a97c-11e9-9dd3-dbf7423595ef.html.*

[12] *https://www.latimes.com/california/story/2019-07-18/massage-therapist-suspected-of-rape-elder-sexual-assault.*

We have an opportunity to renew this effort. There are two possible solutions. The first is to authorize adequate and dedicated funding for States' Adult Protective Services offices to enable them to respond to the growing and increasingly complex reports of elder abuse, neglect and exploitation that all APS programs face.

The second opportunity that could provide more APS funding would be for a set-aside of funds distributed from the Victims of Crime Act (VOCA) Crime Victims Fund to go to direct assistance services for victims of elder abuse, neglect and exploitation. APS must be a priority eligible entity for that set-aside for this reason. All forms of elder abuse, apart from self-neglect, are crimes and its victims are crime victims. APS by its very nature assists victims by investigating the allegations of abuse and providing and referring victims to essential community services to keep victims safe from further abuse and to remain able to live in their homes and communities.

Allowing for these VOCA resources and fully funding the authorization in the bill for APS could be very instrumental in enabling APS to respond effectively to the growth in serious abuse cases. We are hopeful your bill will include not only the set-aside language but an improved definition of victim services and who can provide it.

Long-Term Care Ombudsman Program

Core grants to improve the State long-term care ombudsman program are also critical. Here again, we hope we can build up from the proposed authorization levels in this bill to ensure adequate funding for this important program.

Ombudsmen are the eyes and ears in facilities. According to the National Ombudsman Reporting System, in 2017 ombudsmen made more than 29,000 visits nationwide. These visits give residents a chance to speak up about abuse. In 2017, ombudsman programs investigated more than 5,000 cases of abuse, neglect, or exploitation in assisted living facilities, and over 11,000 cases in nursing homes. In 2016, ombudsman and their trained volunteers investigated 199,493 complaints made by 129,559 individuals. Ombudsmen were able to resolve or partially resolve 74 percent.

We have an opportunity to remedy a shortcoming from the original EJA which authorized a number of important programs that either supported the ombudsman program directly or strengthened other programs or parts of the long-term care systems with which the ombudsman work.

Unfortunately, the funding was never appropriated for the two grant programs that would have supported ombudsman services and elder abuse related training to better equip ombudsman representatives to address resident complaints about abuse and neglect. Neither was funding provided for the training of the nursing home workforce which would benefit both residents and ombudsmen. We sincerely hope some of this can be remedied through your upcoming bill.

We also respectfully recommend that separate authority be provided to allow funding for ombudsman to be provided through the Medicare trust fund, a position supported by the Leadership Council of Aging Organizations.

Elder Justice Coordinating Council and Advisory Board

Another core part of the original EJA is the Elder Justice Coordinating Council (EJCC). We see that as one of the enduring successes of the EJA, accomplished by strong implementation work by both the Obama and Trump Administrations. Today, 14 Federal agencies are communicating and meeting with each other through working groups to learn more about how to coordinate their resources and activities in the elder abuse prevention space. This constitutes a smart use of Federal funds by using what we have and making it more effective through coordination. I am also pleased to note that the EJCC is embarking on a stakeholder listening session process beginning next week at the annual meeting of the National Association of Area Agencies on Aging. At this juncture I would like to salute Kathy Greenlee from the Obama administration and the current co-chairs of the EJCC Lance Robertson and Toni Bacon for their great work.

We also strongly support the convening of the complementary citizen-based Advisory Board on Elder Abuse, Neglect, and Exploitation. Its value can be as an expert panel to advise the Federal Government, including the EJCC, on stories, best practices, and statistics from the field.

Forensic Elder Abuse Centers

The final core item from the original EJA is its call for grants to establish forensic elder abuse centers. The Elder Abuse Forensic Center model is designed to provide case review by a multidisciplinary team, consultation, assessment, tracking, and help to implement person-centered case plans in the most complex cases of abuse, neglect, exploitation, and self-neglect of older adults. Research published by The Gerontological Society of America States that "elder abuse forensic centers improve victim welfare by increasing necessary prosecutions and conservatorships and reducing the recurrence of protective service referrals. Elder abuse forensic centers provide a process designed to efficiently address client safety, client welfare and protection of assets."[13]

It is time the field of elder abuse had access to specialized forensic centers to assist in so many aspects of the work around prevention, including and especially in hospital emergency rooms or clinics to discern whether an older adult who comes in with a bruise has had a fall—or possibly, has been physically abused.

NURSING HOME REFORM POSITIONS

Overall, we also commend your strong interest in promoting meaningful nursing home reform. It is meaningful for residents and their families.

Nursing Home Compare

Regarding reforms to Nursing Home Compare, I was in the audience at your hearing in March 2019 when Patricia Olthoff-Blank testified about her mother dying from dehydration and neglect in a facility that had received a 5-star rating from CMS. That brought the need for reform front and center. We hope HHS after its evaluation will recommend adding consumer satisfaction data to the rating system. We are advised that a good existing model may already exist in the HHS Agency for Healthcare Research and Quality (AHRQ). After all, this was to be to the benefit of consumers to begin with.

Oversight and Reporting Provisions

We agree with all efforts to enhance Federal oversight into abuse and neglect in nursing homes. One method would provide for development and the offering of training to State and Federal surveyors on best practices for identifying and reducing adverse events in LTC facilities. This provision grew out of a recommendation from a 2014 report from the Office of the Inspector General (OIG) of HHS. Hopefully this can be included in the legislation.

The testimony and report provided to the committee by the United States Government Accountability Office reflects what nursing home resident advocates have been saying for many years. It validates the fact that much of the abuse, neglect, and exploitation that takes place behind the closed doors of long-term care facilities is severely underreported by residents, family, staff, and the State survey agencies. There are various reasons for this including the fear of retaliation, but CMS acknowledges the fact. Unfortunately, the GAO report shows that abuse deficiencies more than doubled over the 5-year period from 2013 to 2017, and we believe that this was likely the case in assisted living facilities as well. These were often cases categorized at the highest levels of severity, "causing actual harm to residents or putting residents in immediate jeopardy."

This data and the shocking fact that it may be just the tip of the iceberg, make this hearing and the bill that you are developing even more urgent. Better oversight by CMS is needed that includes tools that nursing homes are mandated to use to record and report abuse and perpetrator type. We need to be sure that reports are made in a timely manner for the treatment and safety of the resident.

For us to achieve reform, we must focus on the prompt reporting to the appropriate law enforcement agency or Adult Protective Services offices by both nursing homes themselves and by State and Federal surveyors of suspected incidents of potential abuse or neglect at skilled nursing facilities (SNFs) and group homes receiving reimbursement from either Medicare or Medicaid.

In fact, according to the OIG, SNFs failed to report an estimated 6,608 instances of potential abuse or neglect (as identified in high-risk hospital ER Medicare claims) to the Survey Agencies in 2016, and additionally, approximately 27 percent of abuse and neglect claims were not reported to law enforcement by mandatory reporters,

[13] *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4944537/.*

even though all States require certain individuals to report suspected abuse, neglect, or exploitation of vulnerable adults.[14]

Further, we have not been as aggressive as we should about tying conditions of participation in the Medicare and Medicaid programs to ensuring that nursing homes and long-term care facilities are free from abuse and neglect.

Resident Safety

We strongly support the idea of mandating that HHS work to better promote awareness on nursing home safety and hospital safety efforts by methods such as posting on the HHS website a list of potential nursing home events, including events that are not commonly associated with SNF care, to help nursing home staff better recognize adverse events.

Our Nation has heard enough horror stories associated with natural disasters and the special vulnerability of nursing home residents. From New Orleans to Hollywood, FL, we have seen terrible conditions caused by hurricanes and floods. This needs to be specifically addressed in your bill. The key must be the coordination between State, local and tribal governments and the Federal Emergency Management Agency on developing and implementing emergency response plans.

We commend the recent work of Senators Casey and Toomey on special focus facilities and hope the new bill can build on this work and mandate that HHS release the full list of facilities in this program and update it on a regular basis.

Chairman Grassley, we know of both your pioneering and long-standing commitment to combating social media abuses in long-term care facilities and hope some specific language will be included in the legislation.

Background Checks

Finally, we hope that your proposed bill will include continued authority to promote criminal background checks of employees at long term care facilities.

Our Coalition has been very interested in this issue since it first appeared as a demonstration program in the Medicare Modernization Act of 2003. The limited outcome of that demonstration conducted in seven States showed why it is necessary. Back then, it was estimated that more than 7,000 individuals were turned away from employment because of what was found on their background check.[15]

This led to Congress passing and President Obama signing into law in 2010 a part of the Affordable Care Act that provided grants to States to implement background check programs for prospective long-term care employees. The program has met more limited than impactful success. First, only 25 States participated in the program, and within those States, according to an OIG interim report, there were varying degrees of implementation. This ranged from some States not obtaining legislation to enable them to conduct the checks to not having a process to collect fingerprints and monitor criminal history information after someone began employment. As a result, only six of the 25 States submitted enough data to CMS to be able to determine the percentage of prospective employees who were disqualified because of their background checks.

Perhaps this is most disturbing. In those same six States, only three percent were disqualified. Some improvements are needed for this program to achieve its critically important goal—to keep criminals from working with older adults in long term care facilities.

We commend Senator Wyden for his leadership on making necessary improvements in the background check program, particularly his support of requirement that SNFs who are participating in Medicare and Medicaid report to the HHS Secretary within six months on the nature of criminal or other background checks used to assess current and prospective personnel who serve as certified nursing assistants. This should be followed by an implementation of improved background checks.

CONCLUSIONS

Essentially, this hearing and the legislation which will follow conveys some important messages. The Federal commitment to promoting elder justice is continued and expanded. It is our longstanding belief that the best role the Federal Government

[14] HHS Office of Inspector General, "Incidents of Potential Abuse and Neglect at Skilled Nursing Facilities Were Not Always Reported and Investigated" (A–01–16–00509), June 2019.

[15] *https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/Downloads/White8-2008.pdf.*

can play is to provide adequate resources to allow those programs at the State and local level, like ombudsmen and Adult Protective Services, to do their important work at top effectiveness. It is also about having existing Federal funds be used in a more coordinated way; extending the Elder Justice Coordinating Council assists in this.

But the nursing home reforms are really the heart of this hearing. I note that there are plenty of high-quality nursing homes in this Nation staffed by dedicated persons. I know this because my mother was a resident in one. They are not the object here, and neither should they be victimized by stigmatizing nursing homes. The focus of this hearing are those nursing homes that fail to adhere to appropriate standards of care and in the process jeopardize the health and safety of residents.

The fault is not only in the facility. Some of the fault rests with lax enforcement of laws enacted to prevent these abuses. All our collective efforts must be directed at achieving full enforcement of any law passed by Congress.

One of the hardest decisions for any individual or family to make in their lifetime is to determine that a loved requires care in a nursing home or long-term care facility. The decision alone is heart-wrenching. To then compound that with uncertainty about the quality of care their loved one will receive is absolutely wrong. The Federal Government has the absolute responsibility to not enable abuse and neglect to occur in those facilities by providing financial support without accountability. Further, the Federal Government has the absolute responsibility to provide consumers with reliable information on the quality of any nursing home or long-term care facility before even one night is spent there.

Sadly, we suffer from an intergenerational cycle of abuse in our Nation, from child abuse to domestic violence to elder abuse. Yet, whereas the Federal response to child abuse and domestic violence has been there for more than 45 years, we still lag way behind in addressing the very real problem of elder abuse. Our Federal commitment to addressing child abuse and domestic violence is paying off: reports of both are decreasing. This is not the case with elder abuse. Failure to improve the Federal response to elder abuse may be one of the worst examples of ageism in public policy.

Going forward on a bipartisan basis, we must be proactive and persistent in our efforts to combat elder abuse and achieve elder justice. Hopefully, this hearing today and the legislation that will be introduced moves us in the right direction. The Elder Justice Coalition looks forward to working closely with this committee on advancing a potential Elder Justice Reform Act and with your colleagues on the Appropriations Committee to get any provisions properly funded.

QUESTIONS SUBMITTED FOR THE RECORD TO ROBERT B. BLANCATO

QUESTIONS SUBMITTED BY HON. CHUCK GRASSLEY

Question. What more, if anything, should we do to support elder abuse victims who are identified through Adult Protective Services (APS) offices? Are caseloads changing, and, if so, what trends are we seeing?

Answer. We need to establish services nationwide that are tailored to older victims, including shelters like those in NY and Arizona. We must work to accomplish prosecution, with a new emphasis on restitution for those whose whole life savings have been taken.

Currently, we are not doing enough to support APS. Nationally, there has been a 15 percent increase in cases just between 2017 and 2018. In States like New York and Minnesota, there have been 100 percent increases over past 7 years. The main funding source for APS, the Social Services Block Grant, or SSBG, has been held with flat funding for several years—even targeted for elimination—and competing demands for SSBG funding result in some States under-funding or not even funding APS at all with Federal dollars.

With the growing indication of a link between elder abuse and opioid abuse, we should closely monitor some of the new funding that is being provided, and as we have recommended in the past, direct some of it into community-based programs like APS and other direct services groups.

We would also like to work with you to have victim services provided by APS be covered under funding from the Crime Victims Fund authorized under the Victims

of Crime Act. We would also like to ensure that programs authorized and funded by VOCA are giving grants to organizations that currently serve victims of elder abuse and suggest that reporting on how their funding is spent be standardized to include this data.

Question. It's my understanding that the opioid crisis has fueled elder abuse and exploitation, with rural areas being especially hard hit by this crisis. What more can you tell us about this subject?

Answer. Drug misuse has shifted to rural areas, particularly Appalachia, New England, and the Midwest, and it's starting to impact older adults. Opioid prescribing rates are higher in rural areas. Nearly half of adults 65+ report chronic pain, and of those, older adults who are low-income or living in rural areas are most likely to use opioids. And, to compound the crisis, some low-income older adults actually sell their unused opioid pills. Also, the opioid epidemic has created a rise in the number of grandparents caring for grandchildren when an addicted parent is unable to do so.

The Elder Justice Coalition jointly with Virginia Tech conducted 4 focus group interviews with involved stakeholders in four States and counties where deaths from opioids were the highest (Kentucky, Ohio, Virginia, West Virginia). Overall, focus group participants reported a 25–35 percent increase in APS cases involving opioids over the past few years.

Other research is showing that the most profound impact of opioid-related cases on APS is case complexity—where additional assessments, medical involvement, increased safety risk, and potentially criminal elements can come into play. Limited resources, especially in rural areas, make these cases extremely challenging.

Question. Is the Elder Justice Coordinating Council still needed and why? How and to what extent does it make a difference in preventing elder abuse, neglect, and exploitation?

Answer. We think the Council, thanks to good implementation work in both the Obama and Trump administrations, has made good progress. Fourteen different Federal agencies aligning is also worthy of note. We should look to see which Federal agencies might be missing. We suggest a possible modification of their role so they can offer input on future elder justice legislation. We suggest they should convene a summit with our coalition, to include all local and State elder justice coalitions. We also suggest that they should advocate for the President to issue proclamation on World Elder Abuse Awareness Day. I've also previously said that they should convene outside of the DC area.

Question. Next year will mark the 10th anniversary of the Elder Justice Act's enactment. What amendments or updates, if any, are needed? Please identify concerns, if any, that you have with activities authorized under that statute, such as training for the long-term care ombudsman program and Adult Protective Services activities.

Answer. We feel that the funding and provisions for APS, the long-term care ombudsmen, the Elder Justice Coordinating Council, and the Advisory Board, and the forensic elder abuse centers should be continued. We also think that the criminal background check program, which was not directly in the Elder Justice Act, should also be extended.

The priority has to be getting elder justice programs funded adequately and that is everyone's job. We appreciate what you did with your Dear Colleague letter supporting funding for elder abuse prevention programs. The administration has to make it a higher priority in its budget; their work in certain areas of elder justice has been commendable like crackdowns on scams through Department of Justice sweeps, but funding for key programs in the Act like the Social Services Block Grant has been a different story.

QUESTIONS SUBMITTED BY HON. RON. WYDEN

SECTION 1150B ENFORCEMENT

Question. One key provision of the Elder Justice Act established new elder abuse reporting requirements for nursing homes (section 1150B of the Social Security Act). The law required immediate reporting of any reasonable suspicion of a crime committed against a nursing home resident. Enforcement measures included civil monetary penalties of up to $300,000. HHS has never given CMS the authority to enforce

this provision. What is the effect of not giving the primary Federal regulator of nursing homes—CMS—the authority to enforce this Federal statute?

Answer. There are a range of elder abuse solutions, from prevention to prosecution. CMS's inability to enforce the Elder Justice Act's civil monetary penalties involve both. I believe that we have missed two opportunities. First, by not imposing civil penalties, we are missing a chance to punish bad facilities. This could prevent further abuse, neglect, and exploitation, and it would show providers that the Federal Government is serious about the quality of care that it pays for in long-term care facilities. Second, we are missing the opportunity to "prosecute," so to speak, using appropriate and mandated civil monetary penalties. I would imagine that such penalties might even gain the attention of the boards of directors of these facilities, who have both fiduciary and ethical responsibilities for the care provided.

REPORTING OF ABUSE AND NEGLECT

Question. We have learned from the Government Accountability Office (GAO) and HHS OIG that incidents of abuse are—across the board— inadequately reported. In Oregon, abuse investigations were not reported to CMS at least since the early 2000's nor incorporated into Nursing Home Compare. The HHS OIG estimated that more than 6,000 incidents of abuse go un-reported by nursing homes each year. Even when abuse is reported, it does not appear to be effectively reported to the public. For example, GAO's recent report shows (at Table 2) that many three, four, and five star homes have incidents of abuse. More than half of the homes cited for abuse deficiencies in a single year are three, four, or five star-rated nursing homes. More than a third of the abuse in nursing homes with abuse deficiencies in multiple years are three, four, and five star-rated homes. What recommendations do you have for ensuring that incidents of abuse are reported and what recommendations do you have for ensuring that the public is aware of them, including changes to Nursing Home Compare?

Answer. First of all, this lack of reporting is unacceptable—further, any time we are not enforcing laws and regulations that protect vulnerable older adults, that is unacceptable. We think that one approach to ensuring reporting is ensuring that any data submitted by a facility to CMS for purposes of star ratings should be subject to audit. Potentially, Nursing Home Compare could also list verified incidents of abuse at facilities.

QUESTIONS SUBMITTED BY HON. SHELDON WHITEHOUSE

Question. Entering a nursing home can be a traumatic time for the patient and his or her family. Often buried deep in the patient admittance contracts are clauses that force patients into secret legal proceedings if the nursing home negligently or even intentionally injures or abuses the patient. Not only does this rob the patient of his or her constitutional right to a day in court, but it also keeps knowledge of the abuse secret from other potential victims.

A 2015 Federal Government study found that less than 7 percent of people who'd signed arbitration agreements as part of credit card contracts understood that it meant they gave up their right to sue the company in the future.

Do you think that nursing home patients, who are already enduring a stressful and emotional situation, are in a position to fully understand what they are signing away?

Answer. As the Elder Justice Coalition said in our 2017 written regulatory comment to the Centers for Medicare and Medicaid Services opposing pre-dispute binding arbitration, "Residents and families often feel they have no choice but to sign the agreement, or they will not be admitted to the facility and receive the care they need." They may not be able to fully understand the risk of signing this agreement. Although our members have various opinions on the rule, one of our members, LeadingAge, has stated as a provider organization that they advise their members not to make arbitration agreements a condition of entry into their nursing homes.

Question. If a nursing home is abusing or neglecting patients, funneling any lawsuits into secretive private legal proceedings allows the nursing home to conceal a pattern of abuse. Correct?

Answer. As stated in our aforementioned comment, "Arbitration lessens the degree of nursing home accountability for poor care, abuse, and neglect."

Question. Don't other current and prospective patients have a right to know if a nursing home is mistreating its patients?

Answer. Current and prospective patients should have access to information about nursing home abuse and neglect.

SUBMITTED BY HON. ROBERT P. CASEY, JR.

U.S. SENATOR BOB CASEY (D–PA)

U.S. SENATOR PAT TOOMEY (R–PA)

June 2019

FAMILIES' AND RESIDENTS' RIGHT TO KNOW: UNCOVERING POOR CARE IN AMERICA'S NURSING HOMES

INTRODUCTION

Many older Americans and people with disabilities living in nursing homes benefit from the care of dedicated leadership and staff members devoted to the health, flourishing and overall well-being of their residents. Investigative reporting, however, continues to identify facilities that fall short of the care standards required of every one of our nation's nursing homes. In such facilities, some residents have experienced outright neglect, such as going without proper nutrition or languishing in filthy conditions. Some older adults and people with disabilities have even experienced physical abuse, sexual assault and premature death.[1]

Alarmingly, recent state survey findings reveal a number of such cases. Over the course of several years, at just one facility in Pennsylvania, documented instances include an unnecessary hospitalization resulting from an avoidable pressure sore, an escaped resident with dementia, mismanagement of medications, unsanitary shower and bathroom areas and uncleaned oxygen tubes.[2] Further, a years-long investigation conducted by *PennLive* revealed an unsettling pattern of poor care in select Pennsylvania nursing homes involving improper wound care, insect infestations, supply shortages and more.[3] Unfortunately, these are not the only instances of drastically substandard care. This report examines federal oversight of our nation's consistently poor-performing nursing homes.

Many documented cases of abuse and neglect occur in facilities affiliated with the federal Special Focus Facility (SFF) program.[4] The SFF program is designed to increase oversight of facilities that persistently underperform in required inspections conducted by state survey agencies.[5] As stipulated by federal law, the SFF program

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[1] "Left to Suffer, A Five-Part Series: Part 1, Abused, Ignored Across Minnesota," *Star Tribune* (November 12, 2017) *(http://www.startribune.com/senior-home-residents-are-abused-and-ignored-across-minnesota/450623913/);* "A Woman in a Vegetative State Suddenly Gave Birth. Her Alleged Assault is a #MeToo Wake-Up Call," *Vox* (January 7, 2019) *(https://www.vox.com/2019/1/7/18171012/arizona-woman-birth-coma-sexual-assault-metoo);* "America's Hidden Horror: Sexual Abuse in Nursing Homes and Care Facilities," *The Sacramento Bee* (April 23, 2017) *(https://www.sacbee.com/news/nation-world/national/article146281039.html);* Senate Committee on Finance, testimony submitted for the record of Patricia Olthoff-Blank, hearing entitled "Not Forgotten: Protecting Americans From Abuse and Neglect in Nursing Homes," 116th Cong. (March 6, 2019) (S. Hrg. 116–282); Senate Committee on Finance, testimony submitted for the record of Maya Fischer, hearing entitled "Not Forgotten: Protecting Americans From Abuse and Neglect in Nursing Homes," 116th Cong. (March 6, 2019) (S. Hrg. 116–282).

[2] Pennsylvania Department of Health, The Gardens at West Shore Inspection Results (Survey: March 8, 2019) (Survey: January 23, 2019) (Survey: October 29, 2018) (Survey: March 16, 2018) (Survey: July 27, 2017) *(http://sais.health.pa.gov/commonpoc/Content/PublicWeb/ltc-survey.asp?Facid=280202&PAGE=1&NAME=GARDENS+AT+WEST+SHORE%2C+THE&SurveyType=H&COUNTY=CUMBERLAND).*

[3] "New Name, Same Nightmare: Golden Living's Homes Changed Hands, but the Care Never Got Better," *PennLive (http://stillfailingthefrail.pennlive.com/3/);* "Failing the Frail," *PennLive* (August 2, 2016) *(https://www.pennlive.com/news/page/failing_the_frail_part_1.html).*

[4] As reflected in the contents of this report.

[5] Centers for Medicare and Medicaid Services, Center for Clinical Standards and Quality/Survey and Certification Group, "Fiscal Year (FY) 2017 Special Focus Facility (SFF) Program Update" (S&C: 17–20–NH) (March 2, 2017) *(https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-20.pdf).*

targets those facilities that "substantially fail" to meet the required care standards and resident protections afforded by the Medicare and Medicaid programs.[6]

Participants of and *candidates* for the SFF program represent only a small fraction of facilities. Of the more than 15,700 nursing homes nationwide, less than 0.6% (a maximum of 88 facilities) are selected for the program. The names of these facilities are made public.[7] An additional 2.5% of facilities (approximately 400 facilities) qualify for the program because they are identified as having a "persistent record of poor care" but are not selected for participation as a result of limited resources at the Centers for Medicare and Medicaid Services (CMS).[8] Despite being indistinguishable from *participants* in terms of their qualifications for enhanced oversight, *candidates* are not publicly disclosed. As a result, individuals and families making decisions about nursing home care for themselves or for a loved one are unlikely to be aware of these *candidates*.

SPECIAL FOCUS FACILITY PROGRAM

PARTICIPANTS: Includes a maximum of 88 nursing homes nationwide. These facilities are subject to more frequent surveying and progressive enforcement actions. The names of these facilities are made public.

CANDIDATES: Includes approximately 400 nursing homes nationwide. These facilities are subject to no additional surveying or other oversight. The names of these facilities are not made public.

On March 4, 2019, U.S. Senators Bob Casey (D–PA) and Pat Toomey (R–PA) wrote to CMS.[9] In that letter, the Senators asked CMS to provide the list of approximately 400 SFF *candidates* and requested information about the program's operations, scope and overall effectiveness. On May 3, 2019, CMS provided a written response to the Senators' inquiry and, on May 14, 2019, the agency transmitted the list of SFF *candidates* for April of 2019 to the Senators.[10]

Senators Casey and Toomey believe that the list of SFF *candidates* is information that must be publicly available to individuals and families seeking nursing care for their loved ones. For that reason, the Senators are releasing the April 2019 list of SFF *candidates* and are continuing to work with CMS to make future lists public. As one caregiver who recently testified before Congress indicated, "I think the more information a consumer gets certainly helps them make an educated decision. . . . It's an extremely difficult decision to make, putting your loved one into a nursing facility. It's heartbreaking, so any information that we can get to help us make a more informed decision, I would be all for."[11]

Through the release of the SFF *candidate* list and this report, which details preliminary findings from surveys and public information about these *candidate* facilities, the Senators aim to provide Americans and their families with the transparency and information they deserve when choosing a home in which to entrust the care of a loved one.

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[6] The Social Security Act of 1935, Pub. L. 74–271, sec. 1819 (f)(8); The Social Security Act of 1935, Pub. L. 74–271, sec. 1919 (f)(8).

[7] Centers for Medicare and Medicaid Services, Center for Clinical Standards and Quality/Survey and Certification Group, "Fiscal Year (FY) 2014 Post Sequester Adjustment for Special Focus Facility (SFF) Nursing Homes" (S&C: 14–20–NH) (April 18, 2014) *(https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-14-20.pdf).*

[8] Centers for Medicare and Medicaid Services, Center for Clinical Standards and Quality/Survey and Certification Group, "Fiscal Year (FY) 2017 Special Focus Facility (SFF) Program Update" (S&C: 17–20–NH) (March 2, 2017) *(https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-20.pdf);* Centers for Medicare and Medicaid Services, briefing with Senate Committee on Aging minority office and Senator Toomey's staff (March 27, 2019).

[9] Letter from Senator Casey and Senator Toomey to Administrator Seema Verma, Centers for Medicare and Medicaid Services (March 4, 2019) *(https://www.aging.senate.gov/imo/media/doc/2019.3.4%20Aging%20Casey%20Toomey%20Letter%20to%20CMS%20Administrator%20re.%20Special%20Focus%20Facilities%20PA%20Final.pdf).*

[10] Letter from Administrator Seema Verma, Centers for Medicare and Medicaid Services, to Senator Casey and Senator Toomey (May 3, 2019) *(https://www.aging.senate.gov/download/cms-response-to-ranking-member-casey);* Centers for Medicare and Medicaid Services, List of Special Focus Facilities (SFF) and Candidates for the SFF Program (May 14, 2019) (copy on file with Senate Committee on Aging minority office).

[11] Senate Committee on Finance, hearing entitled "Not Forgotten: Protecting Americans From Abuse and Neglect in Nursing Homes," 116th Congress (March 6, 2019) (S. Hrg. 116–282).

SPECIAL FOCUS FACILITIES: ***Oversight of Nursing Homes That Persistently Fall Short***

In 1987, on the heels of a groundbreaking Institute of Medicine report on substandard care provided in America's nursing homes, Congress overhauled federal nursing home oversight, enacting reforms to enhance care quality and ensure fair treatment among seniors and people with disabilities living in nursing homes.[12] The *Nursing Home Reform Act* established nursing facility requirements of participation under Medicare and Medicaid and created the federal-state partnership responsible for a range of oversight activities to this day.[13] A 2018 Kaiser Family Foundation report explains, "[t]he law specifically required nursing facilities to provide sufficient nursing, medical and psychosocial services to attain and maintain the highest possible mental and physical functional status of residents."[14] The law also established a comprehensive framework of oversight procedures, including regular surveying and inspections as well as enforcement actions.

Among the reforms enacted was the formation of the Special Focus Facility (SFF) program. As noted above, through this program, Congress directed CMS to more regularly inspect nursing homes that "substantially fail."[15] The law specifically requires SFF *participants* to be surveyed no less than once every 6 months—more frequently than their counterparts, which must be surveyed at least once every 15 months and on average every 12 months statewide.[16]

This surveying provides the backbone for the SFF program. Other components, including the facility selection process and the overall size of the program, are spelled out in CMS guidance.[17] SFF *participants* and *candidates* are identified based on the findings of a nursing facility's three most recent standard surveys. Community input, the results of other state investigations (such as complaint surveys) and other metrics, like staffing data, are not taken into account when determining eligibility for the SFF program.[18] No additional resources or education are provided to either SFF *participants* or *candidates.*

As noted above, CMS also determines the overall size of the SFF program. According to CMS guidance, there are 88 SFF *participants* and 435 *candidates.*[19] The number of *participants* and *candidates* varies by state, but is roughly determined by the number of nursing facilities in that state.[20] In 2013, citing budget and staffing constraints, CMS reduced the program from 152 *participants* to 62 *participants.* A year later, the program grew modestly, to 85 *participants,* and its size has remained relatively constant since.[21]

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[12] Institute of Medicine; Committee on Nursing Home Regulation, "Improving the Quality of Care in Nursing Homes" (1986) *(http://www.nationalacademies.org/hmd/Reports/1986/Improving-the-Quality-of-Care-in-Nursing-Homes.aspx);* Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203.

[13] The Social Security Act of 1935, Pub. L. 74–271, sec. 1819; The Social Security Act of 1935, Pub. L. 74–271, sec. 1919.

[14] Henry J. Kaiser Family Foundation, "Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2009 Through 2016" (April 3, 2018) *(https://www.kff.org/medicaid/report/nursing-facilities-staffing-residents-and-facility-deficiencies-2009-through-2016/).*

[15] The Social Security Act of 1935, Pub. L. 74–271, sec. 1819(f)(8); The Social Security Act of 1935, Pub. L. 74–271, sec. 1919 (f)(8).

[16] *Id.*

[17] Centers for Medicare and Medicaid Services, Center for Clinical Standards and Quality/Survey and Certification Group, "Fiscal Year (FY) 2017 Special Focus Facility (SFF) Program Update" (S&C: 17–20–NH) (March 2, 2017) *(https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-20.pdf).*

[18] Letter from Administrator Seema Verma, Centers for Medicare and Medicaid Services, to Senator Casey and Senator Toomey (May 3, 2019); Centers for Medicare and Medicaid Services, briefing with Senate Committee on Aging minority office and Senator Toomey's staff (March 27, 2019).

[19] Centers for Medicare and Medicaid Services, Center for Clinical Standards and Quality/Survey and Certification Group, "Fiscal Year (FY) 2014 Post Sequester Adjustment for Special Focus Facility (SFF) Nursing Homes" (S&C: 14–20–NH) (April 18, 2014) *(https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-14-20.pdf).*

[20] Centers for Medicare and Medicaid Services, briefing with Senate Committee on Aging minority office and Senator Toomey's staff (March 27, 2019).

[21] Government Accountability Office, "Nursing Home Quality: Continued Improvements Needed in CMS's Data and Oversight" (GAO–18–694T) (September 6, 2018).

Since 2005, more than 900 facilities have been placed on the SFF *candidate* list.[22] New facilities roll onto the SFF program from the list of *candidates* only when space allows (*i.e.,* once another facility "graduates" from the program or is terminated from participation in Medicare and Medicaid). CMS provides each state with the list of *candidates* and relies on the state to select a new *participant* from that list to fill newly-vacated slots in the SFF program.[23]

NURSING HOME COMPARE: ***Transparency in Nursing Home Quality***

In addition to the oversight and enforcement policies described above, Congress has also made it a priority to ensure older adults, people with disabilities and their families have ready access to useful information on nursing home quality.[24] CMS is required to maintain "Nursing Home Compare," an online reference designed to help individuals compare and contrast nursing homes in their community.

The tool's required elements include data on a facility's staffing, information on state surveys as well as specific content on surveys conducted in response to complaints. This information must be provided "in a manner that is prominent, updated on a timely basis, easily accessible, readily understandable . . . and searchable."[25] It is most clearly displayed to the public in the form of star ratings, ranging from the lowest score of one star to the highest score of five stars. A facility's overall rating is determined on the basis of three elements: surveying and inspections, staffing data and quality scores.[26]

Recently, CMS opted to suppress star ratings for *participants* in the Special Focus Facility (SFF) program, namely to "reduce confusion and help consumers understand the current status of each facility's quality."[27] Nursing homes that are *participants* in the SFF program are designated online with a small yellow triangle that resembles a "caution" traffic sign. An individual visiting Nursing Home Compare can hover a cursor over this triangle for a short description of the SFF program and information explaining why the nursing home has no stars displayed. No similar measures are taken on Nursing Home Compare to designate SFF *candidates.*[28]

FINDINGS: ***A Cursory Analysis of Special Focus Facility Participants and Candidates***

As described below, the Senators' inquiry into the Special Focus Facility (SFF) program, including both its *participants* and the April 2019 *candidates,* unveiled several immediate findings.

- A nursing home's participation in the SFF program is not readily transparent or easily understood among would-be residents and their families.

Aside from recent actions by CMS to update Nursing Home Compare so that the website more clearly displays nursing homes that are SFF *participants,* it lacks detailed information or context on the SFF program. There is no information on Nursing Home Compare explaining the reason for a facility's participation in the program, the length of time it has been in the program or whether it has improved.

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[22] "Poor Patient Care at Many Nursing Homes Despite Stricter Oversight," *The New York Times* (July 5, 2017) *(https://www.nytimes.com/2017/07/05/health/failing-nursing-homes-oversight.html).*

[23] Centers for Medicare and Medicaid Services, Center for Clinical Standards and Quality/Survey and Certification Group, "Fiscal Year (FY) 2017 Special Focus Facility (SFF) Program Update" (S&C: 17–20–NH) (March 2, 2017) *(https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-20.pdf).*

[24] The Patient Protection and Affordable Care Act, Pub. L. 111–148, sec. 6103.

[25] The Social Security Act of 1935, Pub. L. 74–271, sec. 1819(i); The Social Security Act of 1935, Pub. L. 74–271, sec. 1919(i).

[26] Centers for Medicare and Medicaid Services, "Design for Nursing Home Compare Five-Star Quality Rating System: Technical Users' Guide" (April 2019) *(https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Downloads/usersguide.pdf).*

[27] Centers for Medicare and Medicaid Services, Center for Clinical Standards and Quality/Quality, Safety and Oversight Group, "April 2019 Improvement to Nursing Home Compare and the Five Star Rating System" (QSO–19–08–NH) (March 5, 2019) *(https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO19-08-NH.pdf).*

[28] Centers for Medicare and Medicaid Services, Nursing Home Compare *(https://www.medicare.gov/NursingHomeCompare/search.html);* Centers for Medicare and Medicaid Services, briefing with Senate Committee on Aging minority office and Senator Toomey's staff (March 27, 2019).

Further, CMS does not include information on facilities that routinely cycle in and out of the SFF program.[29]

Star ratings for most facilities listed on Nursing Home Compare

Star ratings for SFF *Participants* on Nursing Home Compare

Additionally, the Senators' review of Nursing Home Compare suggests that the online tool is not consistently updated to reflect changes in the SFF program. For example, in March 2019, the small icon used to indicate that a facility is a SFF *participant* was not on the webpage of five of the 17 newly-added SFF *participants.*[30]

- Candidates for the SFF program are not disclosed to the public and these facilities do not receive any additional oversight.

The only parties with knowledge that a facility is an SFF *candidate* are CMS, the state in which a *candidate* is based and the facility. While CMS requires every SFF *participant* to notify residents and the community once it has been selected, the same rules do not apply to SFF *candidates.*[31] As such, information on SFF *candidates* is absent on the Nursing Home Compare website. Star ratings continue to be displayed on the Nursing Home Compare webpages for SFF *candidates* and there is no designating icon to indicate a nursing home is a SFF *candidate.*

Several *candidate* facilities possess star ratings that may be misleading. Based upon a review of Nursing Home Compare conducted after the Senators' receipt of the April 2019 *candidate* list, 27% of *candidate* facilities had a two stars out of five overall.[32] The quality and staffing ratings (subcategories of the overall ratings) for these facilities may prove more misleading. Approximately 48% of SFF *candidates* had a

[29] It is worth noting that this lack of information extends to the SFF list, which similarly does not indicate whether a facility was an SFF participant before. For example, one Pennsylvania facility that "recently graduated" in January 2019, was re-added under a different name to the SFF program in February and listed as having only been a part of the program for 1 month despite the fact that the facility was previously in the SFF program for 12 months.

[30] Centers for Medicare and Medicaid Services, Nursing Home Compare *(https://www.medicare.gov/NursingHomeCompare/search.html).*

[31] Centers for Medicare and Medicaid Services, Center for Clinical Standards and Quality/Survey and Certification Group, "Fiscal Year (FY) 2017 Special Focus Facility (SFF) Program Update" (S&C: 17–20–NH) (March 2, 2017) *(https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-20.pdf);* Centers for Medicare and Medicaid Services, briefing with Senate Committee on Aging minority office and Senator Toomey's staff (March 27, 2019).

[32] Centers for Medicare and Medicaid Services, "List of Special Focus Facilities (SFF) and Candidates for the SFF Program.. (May 14, 2019) (copy on file with Senate Committee on Aging minority office).

quality rating of three stars or higher.[33] Similarly, 49% of SFF *candidates* possessed a staffing rating of three stars or greater.[34] Nine SFF *candidates* boasted perfect staffing and quality scores.[35]

Finally, SFF *candidates* are not subject to additional oversight. SFF *candidates* are not surveyed more frequently (aside from surveys following a complaint, which are required) nor are they subject to more rigorous enforcement actions, additional disclosure or reporting requirements.[36] Moreover, CMS does not have a way to add a *candidate* facility to the SFF program if a particularly egregious incident occurs, including any event substantiated by a state investigation or complaint survey.[37]

CONCLUSION:

As evidenced by this report, oversight of America's poorest quality nursing homes falls short of what taxpayers should expect. Senators Casey and Toomey will continue to advocate for increased transparency into consistently underperforming facilities and a robust Special Focus Facility (SFF) program that has the tools it needs to oversee these nursing homes.

APPENDIX A:

Examples of neglect and abuse among SFF participants

- In Georgia, a resident was able to climb out her window and escape. This same resident was found on train tracks with a train approaching.[38]
- In Illinois, a facility failed to provide adequate medical treatment or respond to the concerns of its residents such that one resident who was ill was forced to call 911 himself. When medical personnel came, a nurse tried to prevent his departure from the facility. When the resident finally made it to the hospital, he passed away. According to physicians at the hospital, this resident may have survived had he received treatment sooner.[39]
- In Kansas, a facility failed to give a resident their prescribed medication for 12 days after the person was admitted. According to the surveyor, "[t]his deficient practice represented a significant medication error for the resident who was subsequently re-hospitalized with a blood clot and uncontrolled mental agitation, which required law enforcement intervention."[40]
- In Michigan, a resident who had his catheter removed bled through the night and when he was finally taken to the hospital the next morning, he passed away. An interview with his roommate at the facility revealed that the resident was bleeding and moaning through the night. At this same facility, another resident who repeatedly complained of pain over a month-long period was ignored. The resident was subsequently hospitalized for several weeks due to an infection.[41]
- In Ohio, a facility failed to assess the residents' nutritional status such that surveyors identified 14 residents who had lost weight in the last 30 days. One resident's weight loss was so severe that the person lost 33lbs in 31 days, became lethargic and was hospitalized for malnutrition.[42]

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[33] *Id.*
[34] *Id.*
[35] *Id.*
[36] Centers for Medicare and Medicaid Services, briefing with Senate Committee on Aging minority office and Senator Toomey's staff (March 27, 2019).
[37] *Id.*
[38] Centers for Medicare and Medicaid Services, Nursing Home Compare, Inspection Report from December 19, 2018 *(https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=115564&SURVEYDATE=12/19/2018&INSPTYPE=STD).*
[39] Centers for Medicare and Medicaid Services, Nursing Home Compare, Inspection Report from October 30, 2018 *(https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=145160&SURVEYDATE=10/30/2018&INSPTYPE=CMPL).*
[40] Centers for Medicare and Medicaid Services, Nursing Home Compare, Inspection Report from March 5, 2018 *(https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=175180&SURVEYDATE=03/05/2018&INSPTYPE=CMPL).*
[41] Centers for Medicare and Medicaid Services, Nursing Home Compare, Inspection Report from July 15, 2018 *(https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=235331&SURVEYDATE=07/25/2018&INSPTYPE=CMPL).*
[42] Centers for Medicare and Medicaid Services, Nursing Home Compare, Inspection Report from December 13, 2018 *(https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=365206&SURVEYDATE=12/13/2018&INSPTYPE=CMPL).*

- In Delaware, a facility failed to promptly investigate allegations of sexual assault against a member of staff, which resulted in the victim not being referred to the hospital for examination until 2 days after the incident. Additionally, the facility allowed the alleged perpetrator of the abuse to continue working during the investigation, with access to the victim.[43] As of May 29, 2019, this facility had staffing and quality ratings of five stars.[44]
- In Florida, staff failed to clean and disinfect glucometers between blood tests of several residents, putting them at risk of infection.[45] As of May 29, 2019, this facility had five star staffing and quality ratings.[46]
- In Hawaii, a facility failed to correct an insect infestation such that there were cockroaches and ants near residents, on countertops and crawling on medical charts.[47] As of May 29, 2019, this facility had an overall rating of two stars, with a quality rating of five stars.[48]
- In Kentucky, several residents were placed in immediate jeopardy when the facility failed to provide prescribed medication and treatment and then failed to inform the patients' physician when the treatment was missed. One resident who suffered from a burn wound and was receiving treatment that included a skin graft did not have the dressing changed or showers administered as ordered. Upon inspection, state surveyors found the individual "lying in bed with a large amount of green drainage on dressing and a pool of green drainage on the bed sheets. The resident stated he/she was not sure the last time the dressing had been changed."[49] As of May 29, 2019, this facility had an overall rating of two stars with a staffing rating of four stars.[50]
- In Massachusetts, the availability of illicit substances at one facility was so prevalent that residents had "concerns about maintaining their sobriety at the facility" and "residents reported that it was easier to obtain illicit substances inside the facility than out on the street."[51] As of May 29, 2019, this facility had an overall rating of one star with a staffing rating of three stars.[52]

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[43] Centers for Medicare and Medicaid Services, Nursing Home Compare, Inspection Report from December 6, 2018 *(https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=085001&SURVEYDATE=12/06/2018&INSPTYPE=STD).https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=085001&SURVEYDATE=12/06/2018&INSPTYPE=STD).*

[44] Centers for Medicare and Medicaid Services, Nursing Home Compare, Nursing Home Profile: Kentmere Rehabilitation and Healthcare Center of Wilmington, DE *(https://www.medicare.gov/nursinghomecompare/profile.html#profTab=0&ID=085001&state=DE&lat=0&lng=0&name=KENTMERE%2520REHABILITATION%2520AND%2520HEALTHCARE%2520CENTER&Distn=0.0).*

[45] Centers for Medicare and Medicaid Services, Nursing Home Compare, Inspection Report from April 27, 2018 *(https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=105310&SURVEYDATE=04/27/2018&INSPTYPE=STD).*

[46] Centers for Medicare and Medicaid Services, Nursing Home Compare, Nursing Home Profile: Avante at Ormond Beach, INC. of Ormond Beach, FL *(https://www.medicare.gov/nursinghomecompare/profile.html#profTab=0&ID=105310&Distn=0.0&state=FL&name=AVANTE%20AT%20ORMOND%20BEACH%2C%20INC&lat=0&lng=0).*

[47] Centers for Medicare and Medicaid Services, Nursing Home Compare, Inspection Report from September 14, 2018 *(https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=125026&SURVEYDATE=09/14/2018&INSPTYPE=STD).*

[48] Centers for Medicare and Medicaid Services, Nursing Home Compare, Nursing Home Profile: Kuakini Geriatric Care, INC. of Honolulu, HI *(https://www.medicare.gov/nursinghomecompare/profile.html#profTab=0&ID=125026&state=HI&lat=0&lng=0&name=KUAKINI%2520GERIATRIC%2520CARE%252C%2520INC&Distn=0.0).*

[49] Centers for Medicare and Medicaid Services, Nursing Home Compare, Inspection Report from April 20, 2018 *(https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=185272&SURVEYDATE=04/20/2018&INSPTYPE=STD).*

[50] Centers for Medicare and Medicaid Services, Nursing Home Compare, Nursing Home Profile: River Haven Nursing and Rehabilitation Center of Paducah, KY *(https://www.medicare.gov/nursinghomecompare/profile.html#profTab=0&ID=185272&state=KY&lat=0&lng=0&name=RIVER%2520HAVEN%2520NURSING%2520AND%2520REHABILITATION%2520CENTER&Distn=0.0).*

[51] Centers for Medicare and Medicaid Services, Nursing Home Compare, Inspection Report from September 5, 2018 *(https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=225199&SURVEYDATE=09/05/2018&INSPTYPE=STD).*

[52] Centers for Medicare and Medicaid Services, Nursing Home Compare, Nursing Home Profile: Worcester Rehabilitation and Health Care Center of Worcester, MA *(https://www.medicare.gov/nursinghomecompare/profile.html#profTab=0&ID=225199&state=MA&lat=0&lng=0&name=WORCESTER%2520REHABILITATION%2520%2526%2520HEALTH%2520CARE%2520CENTER&Distn=0.0).*

- In Pennsylvania, a facility failed to ensure that the physician in charge was notified about changes in residents' conditions, which caused a delay in treatment for a resident who subsequently had to be hospitalized, required surgery and developed an embolism.[53] As of May 29, 2019, the facility had an overall rating of one star, but a staffing rating of three stars.[54]
- In Texas, a facility did not prevent the septic system from backing up, causing a foul-smelling black substance to come through the drains seeping into the kitchen floor in close proximity to food preparation areas. The facility continued to serve food to the residents from the kitchen.[55] As of May 29, 2019, this facility had a quality rating of two stars.[56]

APPENDIX B:

United States Senate

WASHINGTON, DC 20510

March 4, 2019

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Administrator Verma:

We are writing on behalf of the 80,000 Pennsylvanians who call a nursing facility home. Recently, select nursing homes in the Commonwealth were the subject of an in-depth investigation into patient neglect and understaffing.[1] Given this report, we are writing to request additional information on the Special Focus Facility (SFF) Initiative, a statutorily required Centers for Medicare and Medicaid Services (CMS) program[2] intended to enhance care quality and foster improvement among nursing facilities that persistently underperform.

We are proud of our state's high-quality nursing facilities, which benefit from dedicated leadership and staff members devoted to their residents' health, flourishing and overall well-being. Recent reporting suggests, however, that there are facilities that fall short of the care standards that we should expect of every one of our nation's nursing homes. As detailed in these reports, despite recent changes in ownership and prior investigations,[3] some of our older constituents and people with disabilities residing in these homes experienced significant harm, including insect infestations, improper wound care, unsanitary conditions, supply shortages, and more.

Neglect and abuse of this nature is altogether unacceptable and through a robust system of competition, monitoring, oversight, technical assistance and enforcement, it should be entirely avoidable. Among the many vital elements of this system, we understand that CMS works alongside the Pennsylvania Department of Health (DoH) to administer the SFF program. Indeed, three of the nursing facilities featured in the aforementioned investigation are current participants in the program.

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[53] Centers for Medicare and Medicaid Services, Nursing Home Compare, Inspection Report from June 7, 2018 *(https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=396056&SURVEYDATE=06/07/2018&INSPTYPE=STD).*

[54] Centers for Medicare and Medicaid Services, Nursing Home Compare, Nursing Home Profile: William Penn Care Center of Jeannette, PA *(https://www.medicare.gov/nursinghomecompare/profile.html#profTab=0&ID=396056&state=PA&lat=0&lng=0&name=WILLIAM%2520PENN%2520CARE%2520CENTER&Distn=0.0).*

[55] Centers for Medicare and Medicaid Services, Nursing Home Compare, Inspection Report from February 1, 2019 *(https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=675553&SURVEYDATE=02/01/2019&INSPTYPE=CMPL).*

[56] Centers for Medicare and Medicaid Services, Nursing Home Compare, Nursing Home Profile: Heritage Healthcare Residence *(https://www.medicare.gov/nursinghomecompare/profile.html#profTab=0&ID=675553&state=TX&lat=0&lng=0&name=HERITAGE%2520HEALTHCARE%2520RESIDENCE&Distn=0.0).*

[1] Daniel Simmons-Ritchie, "Still Failing the Frail," *PennLive,* November 2018, *http://stillfailingthefrail.pennlive.com/.*

[2] 42 U.S.C. 1395i–3; 42 U.S.C. 1396r.

[3] Daniel Simmons-Ritchie and David Wenner, "Failing the Frail," *PennLive,* August 2016, *https://www.pennlive.com/news/page/failing_the_frail_part_1.html.*

We are interested in learning more about the program's operations, scope and overall effectiveness. In continuation of our engagement on these issues, we ask that CMS provide answers to the following questions about the SFF program and the facilities eligible for and/or participating in this initiative:

1. There are more than 15,570 nursing homes in the U.S.[4] Less than one percent (0.6%) participate in the SFF program and less than three percent (2.8%) are eligible for the candidate list. What methodology did CMS use to determine the fixed size of the following:
   a. Total SFF participants nationally (88 facilities);
   b. Total candidates nationally (435 facilities);
   c. Total required participants per state (ranging from 1–6); and
   d. Total candidates per state (ranging from 5–30);[5]
2. CMS guidance[6] indicates the number of candidates and required SFF participants have not been updated since May 2014. Please provide the agency's reasoning for maintaining the program's current size (both candidates and participants), as well as the total number of SFF participants and candidates nationally for each year since 2010;
3. How frequently does CMS update the SFF candidate list? In addition, please provide information on how long a facility typically remains on the candidate list before selection in the SFF program;
4. What process does CMS engage in with state Survey Agencies (SA) to determine which candidates to select for the SFF program? Does CMS require or encourage the SA to take into consideration the scope and severity of deficiencies cited in prior surveys? Does CMS require or encourage the SA take into account any state action that has been taken against a facility?
5. Are there are any circumstances where a facility is prioritized for SFF participation or selected for the program outside of the rolling selection window (*e.g.,* before a slot becomes available upon a participating facility's graduation or termination)?
6. Please indicate what, if any, surveying and oversight actions are taken with respect to candidates *not* selected by SAs for participation in the SFF program;
7. Please provide information on the frequency with which facilities cycle on and off the candidate list and what, if any, surveying, oversight and enforcement actions are taken if those repeat candidates are not selected for the SFF program. Please provide the average length of time a facility remains in the SFF program until graduation and/or termination of federal participation, as well as details on outliers (least amount of time, most amount of time, etc.). Please also provide information on facilities that exit the program without graduating or being terminated from federal participation;
8. CMS makes the list of selected SFF facilities publicly available on a monthly basis; however, the list of potential candidates is provided only to the candidates themselves. Please provide the most recent candidate list and the agency's reasoning for not previously releasing this list to the public; and
9. Pennsylvania's SFF participation includes a minimum of 20 candidates and 4 participants. Please provide the name, address, and length of candidacy for each of the Pennsylvania facilities on the SFF candidate list.

Please provide answers to these questions by March 27, 2019 as well as a briefing for our staff members. If you have any questions, please contact Gillian Mueller of Senator Casey's staff at Gillian_Mueller@casey.senate.gov and Theodore Merkel of Senator Toomey's staff at Theodore_Merkel@toomey.senate.gov. Thank you for your consideration and we look forward to your response.

Sincerely,

Robert P. Casey, Jr.
U.S. Senator

Patrick J. Toomey
U.S. Senator

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[4] CMS, "Provider Info," *Data.Medicare.Gov,* accessed on February 12, 2019, *https://data.medicare.gov/Nursing-Home-Compare/Provider-Info/4pq5-n9py.*

[5] CMS, Center for Clinical Standards and Quality/Survey and Certification Group, "Fiscal Year (FY) 2017 Special Focus Facility Program Update," March 2, 2017, *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-20.pdf.*

[6] *Ibid.*

APPENDIX C:

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare and Medicaid Services

May 3, 2019

Administrator
Washington, DC 20201

The Honorable Robert P. Casey, Jr.
U.S. Senate
Washington, DC 20510

Dear Senator Casey:

Thank you for your letter about the Special Focus Facility (SFF) program. The Centers for Medicare and Medicaid Services (CMS) takes very seriously our responsibility to hold nursing facilities serving Medicare and Medicaid residents accountable for furnishing safe, quality care for our beneficiaries. Earlier this month, I emphasized CMS's commitment to nursing home safety by announcing our five-part plan to ensure the care provided in America's nursing homes is of the highest possible quality.[1] That plan focuses on strengthening requirements for nursing homes, working with states to enforce statutory and regulatory requirements, increasing transparency of nursing home performance, and promoting improved health outcomes for nursing home residents—all without unnecessary paperwork that keeps providers from focusing on residents.

The methodology for identifying facilities for the SFF program is based on the same methodology used in the health inspection domain of the Five-Star Quality Rating System.[2] The results of each facility's surveys for three cycles of inspection are converted into points based on the number of deficiencies cited and the scope and severity level of those citations. The more deficiencies that are cited, and the more cited at higher levels of scope and severity, the more points are assigned. The facilities with the most points in a stale then become candidates for the SFF program. CMS informs nursing homes of their status as an SFF candidate in their individual monthly Five-Star Quality Rating System preview report. Stakeholders can also see which facilities could be candidates by accessing the data.medicare.gov website and downloading the "Provider Info" file:[3] By sorting the column named, "Total Weighted Health Survey Score," in descending order, the facilities with the highest survey scores, which could be SFF candidates appear at the top of the list.

The total number of SFF slots and total number of SFF candidates nationally are based on the availability of federal resources. Under the SFF program's requirements, states must survey these poor performing facilities at least once every 6 months, instead of once every 9–15 months (for non-SFFs). In 2010, there were 167 SFF slots and 835 candidates for the SFF program. In 2014, federal budget reductions, as part of sequestration, led to a reduction in the number of slots nationally to 88, and the candidates were reduced to 440. The number of slots and facilities on the candidate list has remained unchanged since 2014, with sequestration still in place.

The number of nursing homes on the candidate list is based on five candidates for each SFF slot. CMS sends a list of candidate facilities to CMS regional offices and state agencies each month. State agencies then recommend a facility to be an SFF from the candidate list. We rely on the state agency to make the selection since they know their nursing homes and local markets best. The CMS regional office gives final approval based on the state's recommendations. More information on the SFF program and a list of the number of SFF slots and candidates by State is included in the Survey and Certification Memo 17–20–NH.[4]

The SFF candidate list is updated each month based on the most recent findings from surveys conducted in a state. A state only selects a facility from the candidate

[1] *https://www.cms.gov/blog/ensuring-safety-and-quality-americas-nursing-homes.*
[2] More information about Nursing Home Compare is available at: *https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcompliance/downloads/userguide.pdf.*
[3] *https://data.medicare.gov/Nursing-Home-Compare/Provider-Info/4pq5-n9py.*
[4] *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-20.pdf.*

list if there is an open SFF slot in their state. SFF slots are opened when a facility either graduates from the SFF program, or is terminated from participating in the Medicare and Medicaid programs. Facilities typically remain as a candidate for the SFF program for approximately 18 months.

SFFs are expected to graduate from the program within 12–18 months. To graduate from the program, the facility needs have two standard surveys without serious deficiencies identified. At least 6 months apart. If facilities are unable to graduate, they are subject to increased enforcement actions or termination. There are infrequent cases where we have prolonged a facility's status as an SFF (*e.g.,* for greater than 18 months) because of concerns about access to care if the facility were terminated. However, if a facility fails to improve, they will be terminated from participating in Medicare and Medicaid.

While the SFF candidate list is not released publicly, we are evaluating the authority to release this list, and will update you on our progress. We note that facilities that are candidates for the SFF program will typically have a very low star rating. So, consumers and other stakeholders are alerted to the quality of care issues in these facilities by viewing their star rating and survey results on the Nursing Home Compare website. We also note that stakeholders can understand which facilities are likely SFF candidates by accessing the *data.medicare.gov* website as are described above.

Regardless of participation in the SFF program, any facility that performs poorly on surveys and continues to jeopardize residents' health and safety will be subject to CMS enforcement remedies, such as civil money penalties, denial of payment for new admissions, or termination.

In addition to survey oversight, CMS has made great strides to improve the accuracy of data on Nursing Home Compare, including moving to new, more reliable sources for obtaining staffing and resident census data, as well as including more claims-based quality measures. For example, in March 2019, we announced significant changes to Nursing Home Compare and the Five Star Quality rating system in this regard. This includes a change to not display star ratings for SFFs in order to better highlight and emphasize the seriousness of being a SFF.

Information on all these changes can be found in CMS memorandum QSO 19–08–NH.[5] These transparency and oversight initiatives are part of CMS's broader five-part plan to strengthen resident safety and health outcomes while providing consumers and their caregivers important information about care quality so they can make informed decisions. I appreciate your leadership on this important matter and I look forward to working with you to continue to improve the quality of nursing home care. I will also share a copy of this response with the co-signer of your letter.

Sincerely,

Seema Verma

APPENDIX D:

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

OFFICE OF LEGISLATION

May 14, 2019

The Honorable Robert P. Casey, Jr.
Ranking Member
Special Committee on Aging
U.S. Senate
Washington, DC 20510

BY E-MAIL

Dear Ranking Member Casey:

[5] *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO19-08-NH.pdf.*

As a further response to the March 4 letter to the Centers for Medicare and Medicaid Services (CMS) from you and Senator Toomey, please find attached the most recent list of Special Focus Facilities (SFF) and candidates for the SFF program. If you have any further questions, please contact the CMS Office of Legislation.

Sincerely,

Alec Aramanda
Director
Office of Legislation

Enclosure

As of April 2019

Federal Provider Number	Provider Name	State Name	Special Focus Status
015032	DIVERSICARE OF FOLEY	Alabama	SFF Candidate
015467	TRUSSVILLE HEALTH AND REHABILITATION CENTER	Alabama	SFF Candidate
015060	TERRACE OAKS CARE AND REHABILITATION CENTER	Alabama	SFF Candidate
015183	NORTH MOBILE NURSING AND REHABILITATION CENTER	Alabama	SFF Candidate
015144	AHAVA HEALTHCARE OF ALAEASTER	Alabama	SFF
035242	CHINLE NURSING HOME	Arizona	SFF Candidate
035216	CARING HOUSE	Arizona	SFF Candidate
035072	PHOENIX MOUNTAIN POST ACUTE	Arizona	SFF Candidate
035263	ARCHIE HENDRICKS SENIOR SKILLED NURSING FACILITY	Arizona	SFF Candidate
035085	VILLA CAMPANA REHABILITATION HOSPITAL LLC	Arizona	SFF
045203	COMMUNITY COMPASSION CENTER OF BATESMLLE	Arkansas	SFF Candidate
045166	CRESTPARK WYNNE, LLC	Arkansas	SFF Candidate
045267	LEGACY HEALTH AND REHABILITATION CENTER	Arkansas	SFF Candidate
045311	DAVIS EAST	Arkansas	SFF Candidate
045451	COMMUNITY COMPASSION CENTER OF YELLVILLE	Arkansas	SFF Candidate
045144	DIAMOND COVE, LLC	Arkansas	SFF
055476	FIRCREST CONVALESCENT HOSPITAL	California	SFF Candidate
555139	BEVERLY WEST HEALTHCARE	California	SFF Candidate
555566	CORONA POST ACUTE	California	SFF Candidate
055293	SANTA ANITA CONVALESCENT HOSPITAL	California	SFF Candidate
555773	SKY HARBOR CARE CENTER	California	SFF Candidate

As of April 2019—Continued

Federal Provider Number	Provider Name	State Name	Special Focus Status
555061	GOOD SHEPHERD HEALTH CARE CENTER OF SANTA MONICA	California	SFF Candidate
555780	DEL RIO GARDENS CARE CENTER	California	SFF Candidate
056122	MILLBRAE SKILLED CARE	California	SFF Candidate
555057	LAS FLORES CONVALESCENT HOSPITAL	California	SFF Candidate
056346	YUBA SKILLED NURSING CENTER	California	SFF Candidate
555350	TERRACINA POST ACUTE	California	SFF Candidate
055364	LONG BEACH HEALTHCARE CENTER	Calilomia	SFF Candidate
056321	OLYMPIA CONVALESCENT HOSPITAL	California	SFF Candidate
555330	RIVERSIDE POSTACUTE CARE	California	SFF Candidate
056361	FORTUNA REHABILITATION AND WELLNESS CENTER, LP	California	SFF Candidate
056039	WELLSPRINGS POST ACUTE CENTER	California	SFF Candidate
056078	LAKEVIEW TERRACE	California	SFF Candidate
555308	LAKE FOREST NURSING CENTER	California	SFF Candidate
555099	LAKEWOOD HEALTHCARE CENTER	California	SFF Candidate
555375	WINDSOR GARDENS CONVALESCENT CENTER OF LONG BEACH	California	SFF Candidate
555565	WINDSOR PALMS CARE CENTER OF ARTESIA	California	SFF Candidate
056311	HOLLYWOOD PRESBYTERIAN MEDICAL CENTER D/P SNF	California	SFF Candidate
055899	ROYAL PALMS POST ACUTE	California	SFF Candidate
555128	DOWNEY COMMUNITY HEALTH CENTER	California	SFF Candidate
055307	LANCASTER HEALTH CARE CENTER	California	SFF Candidate
055612	SHADOWBROOK POST ACUTE	California	SFF Candidate
056261	MERRITT MANOR CONVALESCENT HOSPITAL	California	SFF Candidate
056066	WOODLAND CARE CENTER	California	SFF Candidate
056113	ALEXANDRIA CARE CENTER	California	SFF Candidate
555151	WILLOWS CENTER	California	SFF
555336	KINGSTON HEALTHCARE CENTER, LLC	California	SFF
555884	RIVERSIDE HEIGHTS HEALTHCARE CENTER, LLC	California	SFF
555814	SAN FERNANDO POSTACUTE HOSPITAL	California	SFF

As of April 2019—Continued

Federal Provider Number	Provider Name	State Name	Special Focus Status
056086	LA MARIPOSA CARE AND REHABILITATION CENTER	California	SFF
065290	MONACO PARKWAY HEALTH AND REHABILITATION CENTER	California	SFF
065193	ALPINE LIVING CENTER	Colorado	SFF Candidate
065168	ASPEN LIVING CENTER	Colorado	SFF Candidate
065208	PEARL STREET HEALTH ANO REHABILITATION CENTER	Colorado	SFF Candidate
065248	BETHANY NURSING AND REHAB CENTER	Colorado	SFF Candidate
075348	ADVANCED CENTER FOR NURSING AND REHABILITATION	Colorado	SFF
075211	APPLE REHAB ROCKY HILL	Connecticut	SFF Candidate
075429	MEADOW RIDGE	Connecticut	SFF Candidate
075397	REGALCARE AT NEW HAVEN	Connecticut	SFF Candidate
075200	REGALCARE AT SOUTHPORT	Conneclicut	SFF
085004	BRANDYWNE NURSING AND REHABILITATION CENTER	Delaware	SFF Candidate
085001	KENTMERE REHABILITATION AND HEALTHCARE CENTER	Delaware	SFF Candidate
085006	REGAL HEIGHTS HEALTHCARE AND REHAB CENTER	Delaware	SFF Candidate
085053	THE MOORINGSAT LEWES	Delaware	SFF Candidate
085015	SEAFORD CENTER	Delaware	SFF Candidate
085032	WESTMINSTER VILLAGE HEALTH	Delaware	SFF
106027	AVANTE AT ORLANDO INC.	Florida	SFF Candidate
105158	TALLAHASSEE MEMORIAL HOSPITAL EXTENDED CARE	Florida	SFF Candidate
105250	HUNTINGTON PLACE	Florida	SFF Candidate
105149	NORTH REHABILITATION CENTER	Florida	SFF Candidate
105543	ST, ANDREWS BAY SKILLED NURSING AND REHABILITATION	Florida	SFF Candidate
105038	OCEAN VIEW NURSING AND REHABILITATION CENTER, LLC	Florida	SFF Candidate
105302	OAK HAVEN REHAB AND NURSING CENTER	Florida	SFF Candidate
105140	BRISTOL AT TAMPA REHAB AND NURSING CENTER LLC	Florida	SFF Candidate

As of April 2019—Continued

Federal Provider Number	Provider Name	State Name	Special Focus Status
105310	AVANTE AT ORMOND BEACH, INC.	Florida	SFF Candidate
106098	HAWTHORNE HEALTH AND REHAB OF SARASOTA	Florida	SFF Candidate
105884	EXCEL CARE CENTER	Florida	SFF Candidate
105592	PALM GARDEN OF VERO BEACH	Florida	SFF Candidate
105693	CONSULATE HEALTH CARE OF LAKE PARKER	Florida	SFF Candidate
106015	BRIGHTON GARDENS OF TAMPA	Florida	SFF Candidate
105257	FORT PIERCE HEALTH CARE	Florida	SFF Candidate
105861	CONSULATE HEALTH CARE OF MELBOURNE	Florida	SFF
105416	BENEVA LAKES HEALTHCARE AND REHABILITATION CENTER	Florida	SFF
115482	EAST LAKE ARBOR	Georgia	SFF Candidate
115411	PLEASANT VIEW NURSING CENTER	Georgia	SFF Candidate
115674	WESTMINSTER COMMONS	Georgia	SFF Candidate
115361	BRENTWOOO HEALTH AND REHABILITATION	Georgia	SFF Candidate
115468	PRUITTHEALTH—BLUE RIDGE	Georgia	SFF Candidate
115504	NORTHEAST ATLANTA HEALTH AND REHABILITATION CENTER	Georgia	SFF Candidate
115354	LAGRANGE HEALTH AND REHAB	Georgia	SFF Candidate
115291	WINDERMERE HEALTH AND REHABILITATION CENTER	Georgia	SFF Candidate
115635	CLINCH HEALTHCARE CENTER	Georgia	SFF Candidate
115564	PINEHILL NURSING CENTER	Georgia	SFF
125057	KULANA MALAMA	Hawaii	SFF Candidate
125031	KOHALA HOSPITAL	Hawaii	SFF Candidate
125026	KUAKINI GERIATRIC CARE, INC.	Hawaii	SFF Candidate
125029	SAMUEL MAHELONA MEMORIAL HOSPITAL	Hawaii	SFF Candidate
125015	WAHIAWA GENERAL HOSPITAL	Hawaii	SFF Candidate
125065	LEGACY HILO REHABILITATION AND NURSING CENTER	Hawaii	SFF
135014	CALDWELL CARE OF CASCADIA	Idaho	SFF Candidate
135048	CLEARWATER OF CASCADIA	Idaho	SFF Candidate

As of April 2019—Continued

Federal Provider Number	Provider Name	State Name	Special Focus Status
135042	LACROSSE HEALTH AND REHABILITATION CENTER	Idaho	SFF Candidate
135092	GOOD SAMARITAN SOCIETY—IDAHO FALLS VILLAGE	Idaho	SFF Candidate
135094	WELLSPRING HEALTH AND REHABILITATION OF CASCADIA	Idaho	SFF
146112	GREENTREE OF BRADLEY REHAB	Illinois	SFF Candidate
145439	CHAMPAIGN URBANA NRSG AND REHAB	Illinois	SFF Candidate
145981	SWANSEA REHAB HEALTH CARE	Illinois	SFF Candidate
145333	WEST SUBURBAN NURSING AND REHAB CENTER	Illinois	SFF Candidate
145965	GENERATIONS AT MCKINLEY COURT	Illinois	SFF Candidate
145926	GARDENVIEW MANOR	Illinois	SFF Candidate
146003	GENERATIONS AT MCKINLEY PLACE	Illinois	SFF Candidate
145364	CHAMPAIGN COUNTY NURSING HOME	Illinois	SFF Candidate
146010	ACCOLADE HEALTHCARE OF PONTIAC	Illinois	SFF Candidate
145453	ALDEN TERRACE OF MCHENRY REHAB	Illinois	SFF Candidate
145712	WILLOW CREST NURSING PAVILION	Illinois	SFF Candidate
145825	SOUTH ELGIN REHAB AND HCC	Illinois	SFF Candidate
145555	EDWARDSVILLE NSG AND REHAB CENTER	Illinois	SFF Candidate
145289	HELIA HEALTHCARE OF BELLEVILLE	Illinois	SFF Candidate
145924	HELIA HEALTHCARE OF CHAMPAIGN	Illinois	SFF Candidate
145669	ELEVATE CARE WAUKEGAN	Illinois	SFF Candidate
145424	LANDMARK OF RICHTON PARK	Illinois	SFF Candidate
145135	BURGIN MANOR	Illinois	SFF Candidate
145371	APERION CARE BLOOMINGTON	Illinois	SFF
145160	APERION CARE CAPITOL	Illinois	SFF
146002	APERION CARE CAIRO	Illinois	SFF
145200	FRANKLIN GROVE LIVING AND REHAB	Illinois	SFF
155404	ESSEX NURSING AND REHABILITATION CENTER	Indiana	SFF Candidate
155243	SIGNATURE HEALTHCARE OF LAFAYETTE	Indiana	SFF Candidate
155208	HANOVER NURSING CENTER	Indiana	SFF Candidate

As of April 2019—Continued

Federal Provider Number	Provider Name	State Name	Special Focus Status
155277	APERION CARE VALPARAISO	Indiana	SFF Candidate
155845	SIMMONS LOVING CARE HEALTH FACILITY	Indiana	SFF Candidate
155379	LIFE CARE CENTER OF ROCHESTER	Indiana	SFF Candidate
155670	SIGNATURE HEALTHCARE OF NEWBURGH	Indiana	SFF Candidate
155359	MAJESTIC CARE OF FORT WAYNE	Indiana	SFF Candidate
155357	RAWLINS HOUSE HEALTH AND LIVING COMMUNITY	Indiana	SFF Candidate
155702	APERION CARE PERU	Indiana	SFF Candidate
155491	MAJESTIC CARE OF CONNERSVILLE	Indiana	SFF Candidate
155763	NORTH RIDGE VILLAGE NURSING AND REHABILITATION CENTER	Indiana	SFF Candidate
155685	GOLDEN LIVING CENTER—ELKHART	Indiana	SFF Candidate
155580	APERION CARE TOLLESTON PARK	Indiana	SFF Candidate
155810	VERNON HEALTH AND REHABILITATION	Indiana	SFF
155156	APERION CARE ARBORS MICHIGAN CITY	Indiana	SFF
155721	LAWRENCE MANOR HEALTHCARE CENTER	Indiana	SFF
165497	QHC WNTERSET NORTH, LLC	Iowa	SFF Candidate
165350	FOUNTAIN WEST HEALTH CENTER	Iowa	SFF Candidate
165174	CASA DE PAZ HEALTH CARE CENTER	Iowa	SFF Candidate
165265	QHC FORT DODGE VILLA, LLC	Iowa	SFF Candidate
165453	PEARL VALLEY REHABILITATION AND HEALTHCARE CENTER OF WASHINGTON	Iowa	SFF Candidate
165198	IOWA CITY REHAB AND HEALTH CARE	Iowa	SFF Candidate
165197	CEDAR FALLS HEALTH CARE CENTER	Iowa	SFF Candidate
165578	PREMIER ESTATES OF MUSCATINE	Iowa	SFF Candidate
165586	TIMELY MISSION NURSING HOME	Iowa	SFF Candidate
165161	TOUCHSTONE HEALTHCARE COMMUNITY	Iowa	SFF
165530	GLEN HAVEN HOME	Iowa	SFF
175475	ENTERPRISE ESTATES NURSING CENTER	Kansas	SFF Candidate
175291	GREAT BEND HEALTH AND REHAB CENTER	Kansas	SFF Candidate

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Federal Provider Number	Provider Name	State Name	Special Focus Status
175452	WOODLAWN CARE AND REHAB, LLC, DBA ORCHARD GARDENS HEALTH AND REHAB	Kansas	SFF Candidate
175176	INDIAN CREEK HEALTHCARE CENTER	Kansas	SFF Candidate
175384	FORT SCOTT MANOR	Kansas	SFF Candidate
175213	PINNACLE RIDGE NURSING AND REHAB CENTER	Kansas	SFF Candidate
175471	WESTY COMMUNITY CARE HOME	Kansas	SFF Candidate
175465	VIA CHRISTI VILLAGE PITTSBURG INC.	Kansas	SFF Candidate
175481	MOUNT HOPE NURSING CENTER	Kansas	SFF Candidate
175180	SERENITY CARE AND REHAB	Kansas	SFF
175175	GARDEN VALLEY RETIREMENT VILLAGE	Kansas	SFF
185272	RIVER HAVEN NURSING AND REHABILITATION CENTER	Kentucky	SFF Candidate
185445	WOODCREST NURSING AND REHABILITATION CENTER	Kentucky	SFF Candidate
185414	MOUNTAIN MANOR OF PAINTSVILLE	Kentucky	SFF Candidate
185333	KLONDIKE CENTER	Kentucky	SFF Candidate
185305	SPRINGHURST HEALTH AND REHAB	Kentucky	SFF Candidate
185087	TWIN RIVERS NURSING AND REHABILITATION CENTER	Kentucky	SFF
195610	ST. HELENA PARISH NURSING HOME	Louisiana	SFF Candidate
195500	TIOGA COMMUNITY CARE CENTER	Louisiana	SFF Candidate
195413	LAKE CHARLES CARE CENTER	Louisiana	SFF Candidate
195305	SOUTH LAFOURCHE NURSING AND REHAB	Louisiana	SFF Candidate
195523	BELLE MAISON NURSING AND REHABILITATION LLC	Louisiana	SFF
205072	MARSHWOOD CENTER	Maine	SFF Candidate
205062	BREWER CENTER FOR HEALTH AND REHABILITATION, LLC	Maine	SFF Candidate
205159	SEDGEWOOD COMMONS	Maine	SFF Candidate
205091	OAK GROVE CENTER	Maine	SFF Candidate
205031	ORONO COMMONS	Maine	SFF
215082	AUTUMN LAKE HEALTHCARE AT PIKESVILLE	Maryland	SFF Candidate

As of April 2019—Continued

Federal Provider Number	Provider Name	State Name	Special Focus Status
215084	PATAPSCO VALLEY CENTER	Maryland	SFF Candidate
215085	CATON MANOR	Maryland	SFF Candidate
215025	CADIA HEALTHCARE—WHEATON	Maryland	SFF Candidate
215052	CADIA HEALTHCARE—SPRINGBROOK	Maryland	SFF
225218	OXFORD REHABILITATION AND HEALTH CARE CENTER, THE	Massachusetts	SFF Candidate
225199	WORCESTER REHABILITATION AND HEALTH CARE CENTER	Massachusetts	SFF Candidate
225453	CRAWFORD SKILLED NURSING AND REHABILITATION CENTER	Massachusetts	SFF Candidate
225267	GARDEN PLACE HEALTHCARE	Massachusetts	SFF Candidate
225323	CARE ONE AT PEABODY	Massachusetts	SFF Candidate
225063	MARLBOROUGH HILLS REHABILITATION AND HEALTH CARE CEMTER	Massachusetts	SFF Candidate
225298	NORTHWOOD REHABILITATION AND HEALTHCARE CENTER	Massachusetts	SFF Candidate
225390	PARSONS HILL REHABILITATION AND HEALTH CARE CENTER	Massachusetts	SFF Candidate
225040	JEWSH NURSING HOME OF WESTERN MASS	Massachusetts	SFF Candidate
225467	WORCESTER HEALTH CENTER	Massachusetts	SFF
225189	SWEET BROOK OF WILLIAMSTOWN REHABILITATION AND NURSING CENTER	Massachusetts	SFF
235357	METRON OF BELDING	Michigan	SFF Candidate
235461	CLARKSTON SPECIALTY HEALTHCARE CENTER	Michigan	SFF Candidate
235302	LAURELS OF COLDWATER, THE	Michigan	SFF Candidate
235147	SCHOOLCRAFT MEDICAL CARE FACILITY	Michigan	SFF Candidate
235263	MEDILODGE OF STERLING HEIGHTS	Michigan	SFF Candidate
235296	MEDILODGE OF SOUTHFIELD	Michigan	SFF Candidate
235250	SAMARITAS SENIOR LIVING SAGINAW	Michigan	SFF Candidate
235284	MEDILODGE OF MIDLAND	Michigan	SFF Candidate
235187	CAMBRIDGE EAST HEALTHCARE CENTER	Michigan	SFF Candidate
235330	MEDILODGE OF LIVINGSTON	Michigan	SFF
245544	VICTORY HEALTH AND REHABILITATION CENTER	Minnesota	SFF Candidate

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Federal Provider Number	Provider Name	State Name	Special Focus Status
245052	MOORHEAD REHABILITATION AND HEALTHCARE CENTER	Minnesota	SFF Candidate
245186	BROOKVIEW A VILLA CENTER	Minnesota	SFF Candidate
245148	THE ESTATES AT ST. LOUIS PARK LLC	Minnesota	SFF Candidate
24E507	SOUTHSIDE CARE CENTER	Minnesota	SFF Candidate
245295	THE EMERALDS AT ST, PAUL LLC	Minnesota	SFF Candidate
245397	HAVENWOOD CARE CENTER	Minnesota	SFF Candidate
245183	NORTH RIDGE HEALTH AND REHAB	Minnesota	SFF Candidate
245323	WALKER REHABILITATION AND HEALTHCARE CENTER	Minnesota	SFF Candidate
245184	ROCHESTER EAST HEALTH SERVICES	Minnesota	SFF
245223	BAY VIEW NURSING AND REHABILITATION CENTER	Minnesota	SFF
255163	WOODLAND VILLAGE NURSING CENTER	Mississippi	SFF Candidate
255109	DIVERSICARE OF SOUTHAVEN	Mississippi	SFF Candidate
255252	MS CARE CENTER OF GREENVILLE	Mississippi	SFF Candidate
255206	AURORA HEALTH AND REHABILITATION	Mississippi	SFF Candidate
25A422	WALTER B CROOK NURSING FACILITY	Mississippi	SFF Candidate
255263	MERIDIAN COMMUNITY LIVING CENTER	Mississippi	SFF
265830	KANSAS CITY CENTER FOR REHABILITATION AND HEALTHCARE	Missouri	SFF Candidate
265807	CRESTVIEW HOME	Missouri	SFF Candidate
265578	NORMANDY NURSING CENTER	Missouri	SFF Candidate
265697	GARDEN VALLEY HEALTHCARE CENTER	Missouri	SFF Candidate
265345	LIFE CARE CENTER OF BRIDGETON	Missouri	SFF Candidate
265585	HILLSIDE MANOR HEALTHCARE AND REHAB CENTER	Missouri	SFF Candidate
265319	PARKLANE CARE AND REHABILITATION CENTER	Missouri	SFF Candidate
265607	CRYSTAL CREEK HEALTH AND REHABILITATION CENTER	Missouri	SFF Candidate
265366	MAPLE WOOD HEALTHCARE CENTER	Missouri	SFF Candidate
265425	EDGEWOOD MANOR CENTER FOR REHAB AND HEALTHCARE	Missouri	SFF Gandidate
265529	CHRISTIAN CARE HOME	Missouri	SFF Candidate

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Federal Provider Number	Provider Name	State Name	Special Focus Status
265160	LEWIS AND CLARK GARDENS	Missouri	SFF Candidate
265476	REDWOOD OF RAYMORE	Missouri	SFF Candidate
265402	RANCHO MANOR HEALTHCARE AND REHABILITATION CENTER	Missouri	SFF Candidate
265510	HIDDEN LAKE CARE CENTER	Missouri	SFF
265733	ST. JOHNS PLACE	Missouri	SFF
265703	GREEN PARK SENIOR LIVING COMMUNITY	Missouri	SFF
27A052	MONTANA MENTAL HEALTH NURSING HOME	Montana	SFF Candidate
275044	BIG SKY CARE CENTER	Montana	SFF Candidate
275153	AWE KUALAWAACHE CARE CENTER	Montana	SFF Candidate
275025	HERITAGE PLACE	Montana	SFF Candidate
275134	DEER LODGE	Montana	SFF Candidate
275122	CREST NURSING HOME	Montana	SFF
285137	LIFE CARE CENTER OF OMAHA	Nebraska	SFF Candidate
285113	SIDNEY CARE AND REHABILITATION CENTER, LLC	Nebraska	SFF Candidate
285238	KEYSTONE RIDGE POST ACUTE NURSING AND REHAB	Nebraska	SFF Candidate
285294	VALLEY VIEW SENIOR VILLAGE	Nebraska	SFF Candidate
285095	SCOTTSBLUFF CARE AND REHABILITATION CENTER, LLC	Nebraska	SFF Candidate
285103	PREMIER ESTATES OF FREMONT, LLC	Nebraska	SFF
295100	SIERRA RIDGE HEALTH AND WELLNESS SUITES	Nevada	SFF Candidate
295079	MOUNTAIN VIEW HEALTH AND REHAB	Nevada	SFF Candidate
295029	WHITE PINE CARE CENTER	Nevada	SFF Candidate
295101	DESERT HILLS POST-ACUTE AND REHABILITATION CENTER	Nevada	SFF Candidate
295083	THE HEIGHTS OF SUMMERLIN, LLC	Nevada	SFF
305005	GREENBRIAR HEALTHCARE	New Hampshire	SFF Candidate
305060	BEDFORD HILLS CENTER	New Hampshire	SFF Candidate
305055	OCEANSIDE SKILLED NURSING AND REHABILITATION	New Hampshire	SFF Candidate
305058	SALEMHAVEN	New Hampshire	SFF Candidate

As of April 2019—Continued

Federal Provider Number	Provider Name	State Name	Special Focus Status
305018	DOVER CENTER FOR HEALTH AND REHABILITATION	New Hampshire	SFF
315229	WANAQUE CENTER FOR NURSING AND REHABILITATION, THE	New Jersey	SFF Candidate
315243	MILLVILLE CENTER	New Jersey	SFF Candidate
315054	OUR LADYS CENTER FOR REHABILITATION AND HC	New Jersey	SFF Candidate
315464	CARE ONE AT EVESHAM	New Jersey	SFF Candidate
315235	RIVERSIDE NURSING AND REHABILITATION CENTER	New Jersey	SFF Candidate
315149	STERLING MANOR	New Jersey	SFF Candidate
315216	WATERVIEWCENTER	New Jersey	SFF Candidate
315038	SUMMIT RIDGE CENTER	New Jersey	SFF Candidate
315509	ROOSEVELT CARE CENTER AT OLD BRIDGE	New Jersey	SFF Candidate
315147	NEWGROVE MANOR	New Jersey	SFF
315225	RIVERFRONT REHABILITATION AND HEALTHCARE CENTER	New Jersey	SFF
325116	MESCALERO CARE CENTER	New Mexico	SFF Candidate
325127	THE SUITES RIO VISTA	New Mexico	SFF Candidate
325080	LANDSUN HOMES, INC.	New Mexico	SFF Candidate
325059	ESPANOLA VALLEY NURSING AND REHAB	New Mexico	SFF Candidate
325066	BLOOMFIELD NURSING AND REHABILITATION CENTER	New Mexico	SFF Candidate
325044	MISSION ARCH CENTER	New Mexico	SFF
335249	CAYUGA RIDGE EXTENDED CARE	New York	SFF Candidate
335437	ELLICOTT CENTER FOR REHABILITATION AND NURSING	New York	SFF Candidate
335439	NEW ROC NURSING AND REHABILITATION CENTER	New York	SFF Candidate
335735	BETHLEHEM COMMONS CARE CENTER	New York	SFF Candidate
335640	BUFFALO COMMUNITY HEALTHCARE CENTER	New York	SFF Candidate
335844	THE KNOLLS	New York	SFF Candidate
335593	EMERALD SOUTH NURSING AND REHABILITATION CENTER	New York	SFF Candidate

As of April 2019—Continued

Federal Provider Number	Provider Name	State Name	Special Focus Status
335798	TOWNHOUSE CENTER FOR REHABILITATION AND NURSING	New York	SFF Candidate
335518	SARATOGA CENTER FOR REHAB AND SKILLED NURSING CARE	New York	SFF Candidate
335377	DIAMOND HILL NURSING AND REHABILITATION CENTER	New York	SFF Candidate
335548	ONONDAGA CENTER FOR REHABILITATION AND NURSING	New York	SFF Candidate
335338	BISHOP REHABILITATION AND NURSING CENTER	New York	SFF Candidate
335663	SAFIRE REHABILITATION OF SOUTHTOWN, LLC	New York	SFF Candidate
335412	COOPERSTOWN CENTER FOR REHABILITATION AND NURSING	New York	SFF Candidate
335357	THE PINES HEALTHCARE AND REHAB CENTERS OLEAN CAMPUS	New York	SFF Candidate
335471	UTICA REHABILITATION AND NURSING CENTER	New York	SFF
335840	MEDFORD MULTICARE CENTER FOR LIVING	New York	SFF
345004	PERSON MEMORIAL HOSPITAL	North Carolina	SFF Candidate
345475	TSALI CARE CENTER	North Carolina	SFF Candidate
345115	ACCORDIUS HEALTH AT SALISBURY	North Carolina	SFF Candidate
345155	RANDOLPH HEALTH AND REHABILITATION CENTER	North Carolina	SFF Candidate
345213	UNIVERSAL HEALTH CARE LILLINGTON	North Carolina	SFF Candidate
345370	PINEHURST HEALTHCARE AND REHAB	North Carolina	SFF Candidate
345144	PINE RIDGE HEALTH AND REHABILITATION CENTER	North Carolina	SFF Candidate
345534	SANFORD HEALTH AND REHABILITATION CO	North Carolina	SFF Candidate
345263	MACON VALLEY NURSING AND REHABILITATION CENTER	North Carolina	SFF
345293	RICHMOND PINES HEALTHCARE AND REHABILITATION CENTER	North Carolina	SFF
355042	WESTERN HORIZONS CARE CENTER	North Dakota	SFF Candidate
355080	DUNSEITH COM NURSING HOME	North Dakota	SFF Candidate
355122	RICHARDTON HEALTH CENTER INC.	North Dakota	SFF Candidate
355031	MINOT HEALTH AND REHAB, LLC	North Dakota	SFF Candidate

As of April 2019—Continued

Federal Provider Number	Provider Name	State Name	Special Focus Status
355053	KNIFE RIVER CARE CENTER	North Dakota	SFF Candidate
355074	TRINITY HOMES	North Dakota	SFF
365559	ROLLING HILLS REHAB AND CARE CENTER	Ohio	SFF Candidate
366313	SCIOTO POINTE	Ohio	SFF Candidate
366003	CRYSTAL CARE CENTER OF FRANKLIN FURNACE	Ohio	SFF Candidate
365435	LOGAN CARE AND REHABILITATION	Ohio	SFF Candidate
366400	BEAVERCREEK HEALTH AND REHAB	Ohio	SFF Candidate
365725	LAURELS OF HILLIARD THE	Ohio	SFF Candidate
365874	HUDSON ELMS NURSING HOME	Ohio	SFF Candidate
365272	WHETSTONE GARDENS AND CARE CENTER	Ohio	SFF Candidate
365998	HOLZER SENIOR CARE CENTER	Ohio	SFF Candidate
365342	CARRIAGE INN OF CADIZ INC.	Ohio	SFF Candidate
365925	PREMIER ESTATES OF CINCINNATI—RIVERSIDE	Ohio	SFF Candidate
366202	CRYSTAL CARE OF COAL GROVE	Ohio	SFF Candidate
366300	CANTON CHRISTIAN HOME	Ohio	SFF Candidate
365421	COLUMBUS COLONY ELDERLY CARE	Ohio	SFF Candidate
366101	ELIZA BRYANT CENTER	Ohio	SFF Candidate
365696	CONTINUING HEALTHCARE AT FOREST HILL	Ohio	SFF Gandidate
366278	STOW GLEN HEALTH CARE CENTER	Ohio	SFF Candidate
365425	NEWARK CARE AND REHABILITATION	Ohio	SFF Candidate
366207	ISABELLE RIDGWAY POST ACUTE CARE CAMPUS LLC	Ohio	SFF
365296	FAIRLAWN REHABAND NURSING CENTER	Ohio	SFF
365792	MARIETTA CENTER	Ohio	SFF
365206	UPTOIAN WESTERVILLE HEALTHCARE	Ohio	SFF
365643	PORTSMOUTH HEALTH AND REHAB	Ohio	SFF
375533	GEARY COMMUNITY NURSING HOME	Oklahoma	SFF Candidate
375275	WARR ACRES NURSING CENTER	Oklahoma	SFF Candidate
375339	EDWARDS REDEEMER HEALTH AND REHAB	Oklahoma	SFF Candidate

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Federal Provider Number	Provider Name	State Name	Special Focus Status
375331	HILLCREST NURSING CENTER	Oklahoma	SFF Candidate
375465	COLONIAL MANOR NURSING HOME, INC.	Oklahoma	SFF Candidate
375341	COUNTRYSIDE ESTATES	Oklahoma	SFF Candidate
375400	WINDSOR HILLS NURSING CENTER	Oklahoma	SFF Candidate
375386	QUAIL RIDGE LIVING CENTER, INC.	Oklahoma	SFF Candidate
375466	DRUMRIGHT NURSING HOME	Oklahoma	SFF Candidate
375206	LINDSAY NURSING AND REHAB	Oklahoma	SFF Candidate
375513	THE GOLDEN RULE HOME	Oklahoma	SFF Candidate
375168	AMBASSAOOR MANOR NURSING CENTER	Oklahoma	SFF
385182	CRESWELL HEALTH AND REHABILITATION CENTER	Oregon	SFF Candidate
385264	SECORA REHABILITATION OF CASCADIA	Oregon	SFF Candidate
385277	CREEKSIDE REHABILITATION AND NURSING	Oregon	SFF Candidate
38E157	ROSE CITY NURSING HOME	Oregon	SFF Candidate
385225	PRESTIGE POST-ACUTE AND REHAB CENTER—MCMINNVILLE	Oregon	SFF
396129	WILLOW TERRACE	Pennsylvania	SFF Candidate
395892	GROVE AT LATROBE, THE	Pennsylvania	SFF Candidate
395423	CORNER VIEW NURSING AND REHABILITATION CENTER	Pennsylvania	SFF Candidate
396099	CONNER-WLLIAMS NURSING HOME	Pennsylvania	SFF Candidate
395964	SHIPPENSBURG HEALTH CARE CENTER	Pennsylvania	SFF Candidate
395330	CHELTENHAM NURSING AND REHAB CENTER	Pennsylvania	SFF Candidate
395015	BRIGHTON REHABILITATION AND WELLNESS CENTER	Pennsylvania	SFF Candidate
395881	MOUNTAIN VIEW CARE AND REHABILITATION CENTER	Pennsylvania	SFF Candidate
395830	MEADOW VIEW NURSING CENTER	Pennsylvania	SFF Candidate
395334	CHESTNUT HILL LODGE HEALTH AND REHAB CENTER	Pennsylvania	SFF Candidate
395142	GARDENS AT BLUE RIDGE, THE	Pennsylvania	SFF Candidate
395074	SPRING CREEK REHABILITATION AND NURSING CENTER	Pennsylvania	SFF Candidate
395288	GARDENS AT STROUD, THE	Pennsylvania	SFF Candidate

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Federal Provider Number	Provider Name	State Name	Special Focus Status
395467	CATHEDRAL VILLAGE	Pennsylvania	SFF Candidate
395077	GARDEN SPRING NURSING AND REHABILITATION CENTER	Pennsylvania	SFF Candidate
396056	WILLIAM PENN CARE CENTER	Pennsylvania	SFF Candidate
395223	GARDENS AT WEST SHORE, THE	Pennsylvania	SFF
395500	TWIN LAKES REHABILITATION AND HEALTHCARE CENTER	Pennsylvania	SFF
395382	GROVE AT NORTH HUNTINGDON, THE	Pennsylvania	SFF
395613	FALLING SPRING NURSING AND REHABILITATION CENTER	Pennsylvania	SFF
415113	TOCKWOTTON ON THE WATERFRONT	Rhode Island	SFF Candidate
415049	HEBERT NURSING HOME	Rhode Island	SFF Candidate
415050	SAINT ELIZABETH MANOR EAST BAY	Rhode Island	SFF Candidate
415052	CHARLESGATE NURSING CENTER	Rhode Island	SFF Candidate
415027	OAK HILL HEALTH AND REHABILITATION CENTER	Rhode Island	SFF
425119	COMMANDER NURSING CENTER	South Carolina	SFF Candidate
425310	BLUE RIDGE OF SUMTER	South Carolina	SFF Candidate
425147	LIFE CARE CENTER OF HILTON HEAD	South Carolina	SFF Candidate
425391	COMPASS POST ACUTE REHABILITATION	South Carolina	SFF Candidate
425400	PRUITTHEALTH-BLYTHEWOOD	South Carolina	SFF Candidate
425082	RIVERSIDE HEALTH AND REHAB	South Carolina	SFF
435031	COVINGTON CARE AND REHABILITATION CENTER	South Dakota	SFF Candidate
435115	PALISADE HEALTHCARE CENTER	South Dakota	SFF Candidate
435064	BLACK HILLS CARE AND REHABILITATION CENTER	South Dakota	SFF Candidate
435051	MEADOWBROOK CARE AND REHABILITATION CENTER	South Dakota	SFF Candidate
435032	REGIONAL HEALTH CARE CENTER	South Dakota	SFF
445017	ASBURY PLACE AT MARYVILLE	Tennessee	SFF Candidate
445339	BAILEY PARK CLC	Tennessee	SFF Candidate
445267	GREENHILLS HEALTH AND REHABILITATION CENTER	Tennessee	SFF Candidate
445516	CREEKSIDE CENTER FOR REHABILITATION AND HEALING	Tennessee	SFF Candidate

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Federal Provider Number	Provider Name	State Name	Special Focus Status
445114	WESTMORELAND HEALTH AND REHABILITATION CENTER	Tennessee	SFF Candidate
445283	RAINBOW REHAB AND HEALTHCARE	Tennessee	SFF Candidate
445446	DYERSBURG NURSING AND REHABILITATION, INC.	Tennessee	SFF Candidate
445483	CORNERSTONE VILLAGE	Tennessee	SFF Candidate
445236	LIFE CARE CENTER OF COLUMBIA	Tennessee	SFF Candidate
445174	BROOKHAVEN MANOR	Tennessee	SFF
445354	LAUDERDALE COMMUNITY LIVING CENTER	Tennessee	SFF
675553	HERITAGE HEALTHCARE RESIDENCE	Texas	SFF Candidate
455575	RETAMA MANOR NURSING CENTER	Texas	SFF Candidate
455974	OAK CREST NURSING CENTER	Texas	SFF Candidate
675365	PASADENA CARE CENTER	Texas	SFF Candidate
676383	INSPIRE NEW BOSTON	Texas	SFF Candidate
675052	LAPORTE HEALTHCARE CENTER	Texas	SFF Candidate
455533	SENIOR CARE OF WINDCREST	Texas	SFF Candidate
675079	FOCUSED CARE AT ALLENBROOK	Texas	SFF Candidate
675536	HILL COUNTRY REHAB AND NURSING CENTER	Texas	SFF Candidate
675396	RETAMA MANOR/LAREDO SOUTH	Texas	SFF Candidate
675284	MISSION MANOR HEALTHCARE RESIDENCE	Texas	SFF Candidate
676307	OAK VILLAGE HEALTHCARE LTC PARTNERS. INC.	Texas	SFF Candidate
455517	GARDENDALE REHABILITATION AND NURSING CENTER	Texas	SFF Candidate
455359	CORPUS NURSING AND REHABILITATION LP	Texas	SFF Candidate
676354	SILVERADO HERMANN PARK	Texas	SFF Candidate
455725	OAKMONT HEALTHCARE AND REHABILITATION CENTER OF HUMBLE	Texas	SFF Candidate
455528	RETAMA MANOR NURSING CENTER/LAREDO—WEST	Texas	SFF Candidate
455951	REGAL HEALTHCARE RESIDENCE	Texas	SFF Candidate
455020	COLONIAL MANOR CARE CENTER	Texas	SFF Candidate

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Federal Provider Number	Provider Name	State Name	Special Focus Status
455557	THE PALMS NURSING AND REHABILITATION	Texas	SFF Candidate
675597	FREE STATE CRESTWOOD	Texas	SFF Candidate
455477	LAKE JACKSON HEALTHCARE CENTER	Texas	SFF Candidate
675231	JACINTO NURSING AND REHABILITATION CENTER, LLC	Texas	SFF Candidate
676325	TRISUN CARE CENTER—LAKESIDE	Texas	SFF Candidate
676227	COPPERAS HOLLOW NURSING AND REHABILITATION CENTER	Texas	SFF Candidate
676051	BRIARCLIFF SKILLED NURSING FACILITY	Texas	SFF Candidate
455618	EDEN HOME INC.	Texas	SFF Candidate
675078	GALLERIA RESIDENCE AND REHABILITATION CENTER	Texas	SFF Candidate
676251	LEGEND OAKS HEALTHCARE AND REHABILITATION—NORTH	Texas	SFF
675612	THE WESTBURY PLACE	Texas	SFF
675906	BENBROOK NURSING AND REHABILITATION CENTER	Texas	SFF
675715	PECAN VALLEY HEALTHCARE RESIDENCE	Texas	SFF
675670	TRISUN CARE CENTER—WESTWOOD	Texas	SFF
46A064	PINE CREEK REHABILITATION AND NURSING	Utah	SFF Candidate
465075	ROCKY MOUNTAIN CARE—HUNTER HOLLOW	Utah	SFF Candidate
465108	COPPER RIDGE HEALTH CARE	Utah	SFF Candidate
465086	MOUNTAIN VIEW HEALTH SERVICES	Utah	SFF Candidate
46A071	LOMOND PEAK NURSING AND REHABILITATION, LLC	Utah	SFF
475052	GILL ODD FELLOWS HOME	Vermont	SFF Candidate
475019	ST. JOHNSBURY HEALTH AND REHAB	Vermont	SFF Candidate
475014	BURLINGTON HEALTH AND REHAB	Vermont	SFF Candidate
475026	NEWPORT HEALTH CARE CENTER	Vermont	SFF Candidate
475040	GREEN MOUNTAIN NURSING AND REHABILITATION	Vermont	SFF Candidate
475044	PINES REHAB AND HEALTH CENTER	Vermont	SFF

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Federal Provider Number	Provider Name	State Name	Special Focus Status
495362	ASHLAND NURSING AND REHABILITATION	Virginia	SFF Candidate
495252	BATTLEFIELD PARK HEALTHCARE CENTER	Virginia	SFF Candidate
495246	WOODMONT CENTER	Virginia	SFF Candidate
495336	AUGUSTA NURSING AND REHAB CENTER	Virginia	SFF Candidate
495327	ENVOY OF WESTOVER HILLS	Virginia	SFF
505516	WASHINGTON SOLDIERS HOME	Washington	SFF Candidate
505527	PRESTIGE POST-ACUTE AND REHAB CENTER—EDMONDS	Washington	SFF Candidate
505202	TALBOT CENTER FOR REHAB AND HEALTHCARE	Washington	SFF Candidate
505214	THE OAKS AT FOREST BAY	Washington	SFF Candidate
505114	GARDENS ON UNIVERSITY, THE	Washington	SFF Candidate
505511	PARAMOUNT REHABILITATION AND NURSING	Washington	SFF
515102	PARKERSBURG CENTER	West Virginia	SFF Candidate
515035	RIVERSIDE HEALTH AND REHABILITATION CENTER	West Virginia	SFF Candidate
515066	DUNBAR CENTER	West Virginia	SFF Candidate
515060	HERITAGE CENTER	West Virginia	SFF Candidate
515049	MORGANTOWN HEALTH AND REHABILITATION CENTER	West Virginia	SFF Candidate
515140	TRINITY HEALTH CARE OF LOGAN	West Virginia	SFF
525616	CROSSROADS CARE CENTER OF MAYVILLE	Wisconsin	SFF Candidate
525424	BROOKFIELD REHAB AND SPECIALTY CARE CENTER	Wisconsin	SFF Candidate
525069	MAPLEWOOD CENTER	Wisconsin	SFF Candidate
525504	AUTUMN LAKE HEALTHCARE AT GREENFIELD	Wisconsin	SFF Candidate
525407	ATRIUM POST ACUTE CARE OF APPLETON	Wisconsin	SFF Candidate
525242	KENSINGTON CARE AND REHAB CENTER	Wisconsin	SFF Candidate
525462	MAPLEWOOD OF SAUK PRAIRIE	Wisconsin	SFF Candidate
525271	ALDEN ESTATES OF COUNTRYSIDE, INC.	Wisconsin	SFF Candidate
525578	CEDARBURG HEALTH SERVICES	Wisconsin	SFF Candidate

As of April 2019—Continued

Federal Provider Number	Provider Name	State Name	Special Focus Status
525427	BAY AT MAPLE RIDGE HEALTH AND REHABILITATION, THE	Wisconsin	SFF
525072	KARMENTA CENTER	Wisconsin	SFF
535042	SHEPHERD OF THE VALLEY REHABILITATION AND WELLNESS	Wyoming	SFF Candidate
535034	WESTWARD HEIGHTS CARE CENTER	Wyoming	SFF Candidate
535026	SHERIDAN MANOR	Wyoming	SFF Candidate
535021	WYOMING RETIREMENT CENTER	Wyoming	SFF Candidate
535051	THERMOPOLIS REHABILITATION AND WELLNESS	Wyoming	SFF Candidate
535025	CHEYENNE HEALTH CARE CENTER	Wyoming	SFF

PREPARED STATEMENT OF JOHN E. DICKEN, DIRECTOR, HEALTH CARE, GOVERNMENT ACCOUNTABILITY OFFICE

Nursing Homes: Improved Oversight Needed to Better Protect Residents From Abuse

Chairman Grassley, Ranking Member Wyden, and members of the committee, I am pleased to be here today to discuss our recent report on the abuse of nursing home residents and the Centers for Medicare and Medicaid Services' (CMS) oversight.[1] Nationwide, about 1.4 million elderly or disabled individuals receive care in more than 15,500 nursing homes. These nursing home residents often have physical or cognitive limitations that can leave them particularly vulnerable to abuse. Abuse of nursing home residents can occur in many forms—including physical, mental, verbal, and sexual—and can be committed by staff, residents, or others in the nursing home. Any incident of abuse is a serious occurrence and can result in potentially devastating consequences for residents, including lasting mental anguish, serious injury, or death. News stories in recent years have noted disturbing examples of nursing home residents who have been sexually assaulted and physically abused. However, little is known about the full scope of nursing home abuse, as incidents of abuse may be underreported.

Federal law mandates that nursing homes receiving Medicare or Medicaid payments ensure that residents are free from abuse. To help ensure this, CMS, an agency within the Department of Health and Human Services (HHS), defines the quality standards that nursing homes must meet in order to participate in the Medicare and Medicaid programs.[2] To monitor compliance with these standards, CMS enters into agreements with agencies in each State government—known as State survey agencies—and oversees the work the State survey agencies do. This work includes conducting required, comprehensive, on-site standard surveys of every nursing home approximately once each year and investigating both complaints from the public and incidents self-reported by the nursing home (referred to as facility-

[1] GAO, *Nursing Homes: Improved Oversight Needed to Better Protect Residents From Abuse.* GAO–19–433 (Washington, DC: June 13, 2019).

[2] CMS defines abuse in its guidance, the State Operations Manual (dated November 22, 2017), as "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being." This testimony addresses physical abuse, mental, and verbal abuse—which we refer to as "mental/verbal abuse"—and sexual abuse but does not address other forms of abuse, such as financial abuse or neglect.

reported incidents) regarding resident care or safety.[3] If a surveyor determines that a nursing home violated a Federal standard during a survey or investigation, then the home receives a deficiency citation, also known as a deficiency. In addition to State survey agencies, there are other State and local agencies that may be involved in investigating abuse in nursing homes, including Adult Protective Services, local law enforcement, and Medicaid Fraud Control Units (MFCU) in each State, which are tasked with investigating and prosecuting a variety of health care-related crimes.

We have previously reported on problems in nursing home quality, including challenges protecting residents from abuse and weaknesses in CMS's oversight. For example, in multiple reports dating back to 1998, we have identified weaknesses in Federal and State activities designed to correct quality problems in nursing homes. Specifically, in a 2002 report, we found that CMS needed to do more to protect nursing home residents from abuse, and we made five recommendations to help CMS facilitate the reporting, investigation, and prevention of abuse in nursing homes.[4] More recently, in April 2019 we reported that CMS had failed to address gaps in Federal oversight of nursing home abuse investigations in Oregon—an issue that we uncovered during the course of our broader work on nursing home resident abuse.[5] Further, reports by the HHS Office of the Inspector General (OIG) have also reviewed incidents of resident abuse and raised concerns about CMS's procedures.[6]

My testimony today highlights key findings and recommendations from our June 2019 report, which examined:

1. the trends and types of abuse occurring in nursing homes in recent years,
2. the risk factors for abuse and challenges facing stakeholder agencies involved in investigating abuse in nursing homes, and
3. CMS's oversight intended to ensure that nursing home residents are free from abuse.

To conduct the work for our report, we reviewed Federal laws and CMS guidance, analyzed CMS data, and interviewed stakeholders from selected States. First, we reviewed Federal laws and CMS guidance to determine the Federal standards and associated deficiency codes related to resident abuse. Second, we analyzed data provided by CMS to identify the number and severity of abuse deficiencies cited by surveyors in all 50 States and Washington, DC, between 2013 and 2017.[7] Because abuse and perpetrator type are not readily identifiable in CMS's data, we identified this information by reviewing a randomly selected representative sample of 400 CMS abuse deficiency narratives written by State surveyors from 2016 through 2017 that describe the substantiated abuse. Finally, we interviewed CMS officials and officials from a non-generalizable sample of survey agencies from five States—Delaware, Georgia, Ohio, Oregon, and Virginia. We also interviewed other stakeholders in these States, including officials from each State's long-term care ombudsmen, law enforcement, MFCUs, and, when appropriate, Adult Protective Services. We also visited nursing homes and spoke to administrators and clinical staff in each of these States. We assessed CMS's oversight activities in the context of the Federal standards for internal control.[8] Further details on our scope and methodology are

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[3] By law, every nursing home receiving Medicare or Medicaid payment must undergo a standard survey at least once every 15 months, with a Statewide average interval for surveys not to exceed 12 months. 42 U.S.C. §§ 1395i-3(g)(1)(A), (g)(2)(A)(iii), 1396r(g)(1)(A), (g)(2)(A)(iii).

State survey agencies are also required to investigate complaints and facility-reported incidents filed with State survey agencies. 42 U.S.C. §§ 1395i–3(g)(1)(C), 1396r(g)(1)(C).

[4] One of these recommendations was implemented—that CMS clarify the definition of abuse and otherwise ensure that States apply that definition consistently and appropriately. While CMS generally agreed with the other four recommendations, they were closed as not implemented. *See* GAO, *Nursing Homes: More Can Be Done to Protect Residents From Abuse,* GAO–02–312 (Washington, DC: March 1, 2002).

[5] GAO, *Management Report: CMS Needs to Address Gaps in Federal Oversight of Nursing Home Abuse Investigations That Persisted in Oregon for at Least 15 Years,* GAO–19–313R (Washington, DC: April 15, 2019).

[6] For example, *see* Joanne M. Chiedi, Office of Inspector General, HHS, *Incidents of Potential Abuse and Neglect at Skilled Nursing Facilities Were Not Always Reported and Investigated,* A–01–16–00509 (Washington, DC, June 7, 2019).

[7] CMS restructured its deficiency code system beginning on November 28, 2017. Due to these coding changes, we did not analyze CMS data cited by surveyors after the implementation of that change.

[8] GAO, *Standards for Internal Control in the Federal Government,* GAO–14–704G (Washington, DC: September 10, 2014). Internal control is a process effected by an entity's oversight

Continued

included in our report. The work on which this statement is based was performed in accordance with generally accepted government auditing standards.

IMPROVED CMS OVERSIGHT IS NEEDED TO BETTER PROTECT RESIDENTS FROM ABUSE

In our report, we found that, while abuse deficiencies cited in nursing homes were relatively rare from 2013 through 2017, they became more frequent during that time, with the largest increase in severe cases. Specifically, abuse deficiencies comprised less than 1 percent of the total deficiencies in each of the years we examined, which is likely conservative. Abuse in nursing homes is often underreported by residents, family, staff, and the State survey agency, according to CMS officials and stakeholders we interviewed. However, abuse deficiencies more than doubled—from 430 in 2013 to 875 in 2017—over the 5-year period.[9] (See appendix I.) In addition, abuse deficiencies cited in 2017 were more likely to be categorized at the highest levels of severity—deficiencies causing actual harm to residents or putting residents in immediate jeopardy—than they were in 2013. In light of the increased number and severity of abuse deficiencies, it is imperative that CMS have strong nursing home oversight in place to protect residents from abuse; however, we found oversight gaps that may limit the agency's ability to do so. Specifically, we found that CMS: (1) cannot readily access data on the type of abuse or type of perpetrator, (2) has not provided guidance on what information nursing homes should include in facility-reported incidents, and (3) has numerous gaps in its referral process that can result in delayed and missed referrals to law enforcement.

INFORMATION ON ABUSE AND PERPETRATOR TYPES IS NOT READILY AVAILABLE

We found that CMS's data do not allow for the type of abuse or perpetrator to be readily identified by the agency. Specifically, CMS does not require the State survey agencies to record abuse and perpetrator type and, when this information is recorded, it cannot be easily analyzed by CMS. Therefore, we reviewed a representative sample of 400 CMS narrative descriptions—written by State surveyors—associated with abuse deficiencies cited in 2016 and 2017 to identify the most common types of abuse and perpetrators. From this review, we found that physical abuse (46 percent) and mental/verbal abuse (44 percent) occurred most often in nursing homes, followed by sexual abuse (18 percent).[10] Furthermore, staff, which includes those working in any part of the nursing home, were more often the perpetrators (58 percent) of abuse in deficiency narratives, followed by resident perpetrators (30 percent) and other types of perpetrators (2 percent).[11] (See appendix II for examples from our abuse deficiency narrative review.)

CMS officials told us they have not conducted a systematic review to gather information on abuse and perpetrator type. Further, based on professional experience, literature, and ad hoc analyses of deficiency narrative descriptions, CMS officials told us they believe the majority of abuse is committed by nursing home residents and that physical and sexual abuse were the most common types.[12] This understanding does not align with our findings on the most common types of abuse and perpetrators. Without the systematic collection and monitoring of specific abuse and perpetrator data, CMS lacks key information and, therefore, cannot take actions—such as tailoring prevention and investigation activities—to address the most prevalent types of abuse or perpetrators.[13] To address this, we recommended that CMS require State survey agencies to report abuse and perpetrator type in CMS's data-

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body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

[9] The trend for abuse deficiencies is in contrast to the trend across all types of deficiencies, which decreased about 1 percent between 2013 and 2017. Specifically, all deficiency types increased at a much slower rate than abuse deficiencies each year through 2016 and then decreased slightly through the period examined in 2017.

[10] Percentages may not add to 100 either because some narratives had multiple types of abuse, were missing or incomplete, or were not consistent with CMS's definition of abuse. Upper and lower confidence levels were: physical abuse (41 to 51 percent), mental/verbal abuse (40 to 49 percent), and sexual abuse (14 to 22 percent).

[11] Upper and lower confidence levels were: staff-on-resident abuse (54 to 63 percent), resident-on-resident abuse (26 to 35 percent), and abuse by others (1 to 3 percent). Other types of perpetrators can include family members of residents or other visitors.

[12] CMS officials noted that some incidents resulting from resident altercations—particularly those that do not show a willful intent to harm—may not have been cited as an abuse deficiency by some State survey agencies and may have been cited as other deficiencies not specified as abuse. This may have contributed to the difference between CMS's understanding of the prevalence of resident-to-resident abuse and what their abuse deficiency data show.

[13] The lack of a systematic review is also inconsistent with Federal internal control standards directing management to use quality information to achieve program objectives (GAO–14–704G).

bases for deficiency, complaint, and facility-reported incident data and that CMS systematically assess trends in these data. HHS concurred with our recommendation.

FACILITY-REPORTED INCIDENTS LACK KEY INFORMATION

Despite Federal law requiring nursing homes to self-report allegations of abuse and covered individuals to report reasonable suspicions of crimes against residents, CMS has not provided guidance to nursing homes on what information they should include in facility-reported incidents, contributing to a lack of information for State survey agencies and delays in their investigations.[14] Specifically, officials from each of the five State survey agencies told us that the documentation they receive from nursing homes for facility-reported incidents can lack key information that affects their ability to triage incidents and determine whether an investigation should occur and, if so, how soon. For example, officials from two State survey agencies we interviewed said they sometimes have to conduct significant follow-up with the nursing homes to obtain the information they need to prioritize the incident for investigation—follow-up that delays and potentially negatively affects investigations.[15] Incomplete incident reports from nursing homes are particularly problematic given that nearly half of abuse deficiencies cited between 2013 and 2017 were identified through facility-reported incidents, which is dramatically different than the approximately 5 percent of all types of deficiencies that were identified in this manner. Therefore, facility-reported incidents play a unique and significant role in identifying abuse deficiencies in nursing homes, making it critical that incident reports provided by nursing homes include the information necessary for State survey agencies to prioritize and investigate. To address this issue, we recommended that CMS develop and disseminate guidance—including a standardized form—to all State survey agencies on the information nursing homes and covered individuals should include on facility-reported incidents. HHS concurred with our recommendation.

GAPS EXIST IN CMS PROCESS FOR STATE SURVEY AGENCY REFERRALS TO LAW ENFORCEMENT AND MFCUS

We found gaps in CMS's process for referring incidents of abuse to law enforcement and, if appropriate, to MFCUs. These gaps may limit CMS's ability to ensure that nursing homes meet Federal requirements for residents to be free from abuse. Specifically, we identified issues related to (1) referring abuse to law enforcement in a timely manner, (2) tracking abuse referrals, (3) defining what it means to substantiate an allegation of abuse—that is, the determination by the State survey agency that evidence supports the abuse allegation, and (4) sharing information with law enforcement. We made recommendations to CMS to address each of these four gaps in the referral process, and HHS concurred with each recommendation.

For instance, because CMS requires a State survey agency to make referrals to law enforcement only after abuse is substantiated—a process that can often take weeks or months—law enforcement investigations can be significantly delayed. Officials from one law enforcement agency and two MFCUs we interviewed told us the delay in receiving referrals limits their ability to collect evidence and prosecute cases—for example, bedding associated with potential sexual abuse may have been washed, and a victim's wounds may have healed.[16] As such, we recommended that CMS require State survey agencies to immediately refer to law enforcement any reasonable suspicion of a crime against a resident. HHS concurred with our recommendation.

In conclusion, while nursing home abuse is relatively rare, our review shows that abuse deficiencies cited in nursing homes are becoming more frequent, with the largest increase in severe cases. It is imperative that CMS have more complete and readily available information on abuse to improve its oversight of nursing homes. It is also essential that CMS require State survey agencies to immediately report incidents to law enforcement if they have a reasonable suspicion that a crime against a resident has occurred in order to ensure a prompt investigation of these incidents. As illustrated by this hearing, continued focus from Congress, CMS, GAO,

[14] 42 CFR § 483.12(c)(1); 42 U.S.C. § 1320b–25(b). These covered individuals include nursing home owners, operators, and employees, among others.

[15] The lack of guidance from CMS on the information that State survey agencies should collect on facility-reported incidents is inconsistent with Federal internal control standards directing management to use quality information to achieve program objectives (GAO–14–704G).

[16] Such delays are inconsistent with standards for internal control, which state that management should communicate quality information externally so that external parties can help the entity achieve its objectives (GAO–14–704G).

OIG, State survey agencies, and others are important steps towards ensuring that nursing home residents are protected from abuse.

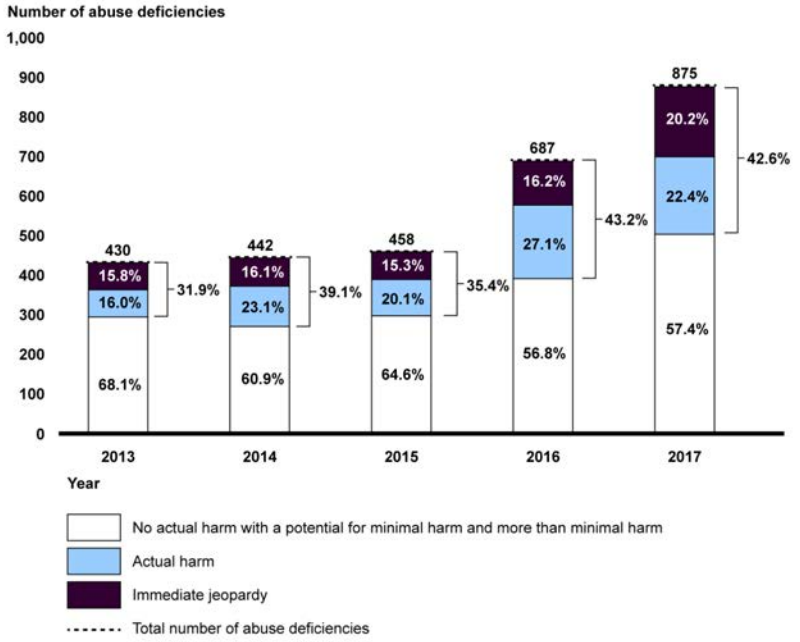
Chairman Grassley, Ranking Member Wyden, and members of the committee, this concludes my statement. I would be pleased to respond to any questions that you may have at this time.

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), Sarah-Lynn McGrath (Analyst-in-Charge), Luke Baron, Julianne Flowers, Laurie Pachter, Kathryn Richter, and Jennifer Whitworth.

Appendix I: Severity of Cited Abuse Deficiencies, 2013 through 2017

Figure 1: Severity of Cited Abuse Deficiencies, 2013 through 2017



Source: GAO analysis of Centers for Medicare & Medicaid Services' (CMS) data. | GAO-19-671T

Notes: CMS categorizes deficiencies into one of four severity categories based on whether the deficiency constitutes: (1) no actual harm with a potential for minimal harm; (2) no actual harm with a potential for more than minimal harm, but not immediate jeopardy; (3) actual harm that is not immediate jeopardy; or (4) immediate jeopardy to resident health or safety. We combined the first two categories in this figure.

CMS restructured its deficiency code system beginning on November 28, 2017. Due to these coding changes, we did not analyze CMS data cited by surveyors after the implementation of that change.

Percentages may not add to 100 due to rounding.

Appendix II: Examples From a Representative Sample of Nursing Home Abuse Deficiency Narratives, 2016–2017

Table 1: Examples From a Representative Sample of Nursing Home Abuse Deficiency Narratives, 2016–2017

Type(s) of abuse	Type(s) of perpetrator	Narrative details	Scope and severity
Physical abuse	Staff	A nurse aide grabbed a resident by both wrists, causing the resident to fall to the floor and resulting in bruising to the resident's left wrist and left hip.	Isolated scope, immediate jeopardy
Physical and sexual abuse	Resident	Resident 1, who had severe cognitive impairment, kicked another Resident 2, who also had significant cognitive impairment, in the face. Separately, Resident 3 shoved Resident 4 against a door, causing Resident 4 to fall. After being helped up by staff, Resident 4 was hit by Resident 3. The same resident (Resident 3) later slapped a different resident—Resident 5 in the head. Also in the narrative, Resident 6 fondled the breast of Resident 7, who appeared confused by the action.	Isolated scope, actual harm
Sexual and mental/verbal abuse	Resident and staff	A cognitively impaired resident (Resident 1) with a history of inappropriate sexual behavior grabbed Resident 2 in a sexually inappropriate manner. Resident 1 then grabbed the "private area" of Resident 3. Separately, a nursing home dietary staff member was verbally abusive to a resident (Resident 4), yelling and antagonizing the resident.	Widespread, immediate jeopardy
Sexual abuse	Staff	A nurse aide found a medical technician sexually assaulting a resident in the resident's room. The resident was nonverbal, with severe dementia, and was totally dependent on staff for mobility. The medical technician "begged" the nursing assistant not to tell anyone about witnessing the assault, and the medical technician later told a supervisor they had "had this problem for a while."	Isolated scope, immediate jeopardy
Mental/verbal abuse	Other	Resident 1 had an argument with Resident 2. Resident 2's family member arrived and threatened to kick Resident 1 out of her wheelchair if she did not stay away from Resident 2. Resident 1 was deeply concerned and felt frightened every time Resident 2's family member visited and she said that she had a nightmare about the family member.	Isolated scope, no actual harm with a potential for more than minimal harm

Table 1: Examples From a Representative Sample of Nursing Home Abuse Deficiency Narratives, 2016–2017—Continued

Type(s) of abuse	Type(s) of perpetrator	Narrative details	Scope and severity
Mental/verbal abuse	Staff	A nurse assistant told a resident to "shut up and (expletive) off" when the resident requested to have their soiled brief changed, and the facility staff member put the resident's call light on the floor under the resident's bed so that the resident would not turn on the call light when they needed care. The State survey agency investigated this complaint, which had not been reported to the facility administrator.	Isolated scope, actual harm

Source: GAO summary of Centers for Medicare and Medicaid Services' (CMS) data (GAO–19–671T).
Notes: We reviewed a representative sample of abuse deficiency narratives from CMS to determine the most common abuse type and perpetrator type.

QUESTIONS SUBMITTED FOR THE RECORD TO JOHN E. DICKEN

QUESTIONS SUBMITTED BY HON. CHUCK GRASSLEY

Question. Your recent report, *Nursing Homes: Improved Oversight Needed to Better Protect Residents From Abuse,* attributes 58 percent of nursing home abuse cases to staff members at the facility. Are the perpetrators mostly certified nursing assistants, who have daily contact with nursing home residents, or are other personnel involved in these cases?

Answer. The June 2019 GAO report did not include an in-depth analysis identifying the staff type involved in abuse. The report included examples of abuse from Centers for Medicare and Medicaid Services' (CMS) narrative descriptions written by State surveyors that document abuse incidents by type of abuse and perpetrator. Perpetrators described in the CMS narratives were categorized by GAO as residents, nursing home staff, which included staff working in any part of the nursing home (such as nursing aides and medical technicians), or others. However, not all narratives GAO reviewed included information on the specific type of staff member involved.

Question. If nursing home personnel account for 58 percent of all abuse cases, does this point to a need for more comprehensive background checks of nursing home employees? Are such background checks more important for certified nursing assistants than for other personnel at nursing homes?

Answer. The June 2019 GAO report did not include analysis of staff perpetrators to determine the extent to which those staff who abused residents received background checks prior to employment, or whether the staff who abused residents had a history of abuse or other risk factors that would have been detected by a background check. GAO did not analyze whether background checks were more important for certain types of staff.

The report did note that, in three of the five States in GAO's review, stakeholders GAO interviewed said that inadequate staff screening can be a risk factor for abuse. In addition, because staff screening through background checks and the nurse aide registry is not coordinated across the country, there are gaps that could enable individuals who committed crimes in one State to obtain employment at a nursing home in another State, a concern that GAO has previously reported.[1]

Question. Does insufficient training of nursing home personnel help explain why all abuse or neglect is not self-reported by nursing homes? What other factors might deter self-reporting of abuse and neglect? To what extent do you agree with the recommendations made by Megan Tinker of the Office of Inspector General in her Senate testimony of July 23, 2019?

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[1] GAO, *Nursing Homes: More Can Be Done to Protect Residents From Abuse,* GAO–02–312 (Washington, DC: March 1, 2002).

Answer. In June 2019, GAO reported that, according to stakeholders interviewed, insufficient or inadequately trained staff may not notice warning signs of abuse, which could result in abuse not being reported. Stakeholders also told GAO that nursing home staff may be afraid to report abuse because they think reporting abuse will result in them losing their jobs or facing retaliation from co-workers. In addition, abuse may be underreported because residents themselves fear retaliation from staff, or because residents who are cognitively impaired may have difficulty recalling an incident of abuse and therefore may not be able to describe what happened. The Office of the Inspector General (OIG) for the Department of Health and Human Services (HHS) also identified issues with the reporting of potential abuse and neglect in nursing homes and recommended CMS take action, potentially through providing training or by clarifying guidance, to ensure that incidents of potential abuse or neglect in nursing homes are identified and reported.

Question. Is GAO satisfied with the progress that CMS has made in improving its Nursing Home Compare website and the five-star rating system for nursing homes? What, if any, open recommendations has GAO made in that area that CMS has not committed to implement, and why? What more should CMS or Congress do in this area?

Answer. GAO has reported on the CMS Nursing Home Compare website and its Five-Star Rating System in a number of reports.[2] Most recently GAO issued reports in 2015 and 2016 that focused on issues such as the nursing home quality data that help inform the website and rating system and areas for improvement in the website and rating system, respectively.[3]

Two of the three recommendations from GAO's 2015 report on nursing home quality remain open, including that CMS should implement a clear plan for ongoing auditing of self-reported data and establish a process for monitoring oversight modifications to better assess their effects.

One of the four recommendations from GAO's 2016 report on the website and rating system has not been acted on by CMS. To help improve the Five-Star System's ability to enable consumers to understand nursing home quality and make distinctions between high- and low-performing homes, GAO recommended CMS add information to the Five-Star System that allows consumers to compare nursing homes nationally. HHS did not concur with this recommendation, and, as of July 2019, CMS officials indicated no actions have been taken to implement this recommendation. GAO maintains that adding national comparison information is important. In addition, GAO's 2016 report found a number of other factors that may inhibit the ability of consumers to use the Five-Star System ratings as intended. For instance, because the Five-Star System does not include consumer satisfaction information—a key quality performance measure—the rating system is missing important information that could help consumers distinguish between high- and low- performing nursing homes.

Additionally, in an April 2019 report, GAO reported that prior to an Oregon policy change in 2018, CMS's Nursing Home Compare website did not have complete information on Oregon nursing homes, particularly related to issues of abuse.[4] GAO recommended, among other things, that CMS clearly communicate to consumers the lack of data on abuse in Oregon nursing homes contained in the CMS Nursing Home Compare website. HHS concurred with the recommendation. GAO will continue to follow up with CMS and track their progress on this recommendation.

Question. By law, nursing home personnel must immediately report certain suspected crimes to law enforcement and State agencies. But, as you testified, there's no equivalent requirement that State agencies investigate or otherwise pursue these complaints. You noted that CMS also does not conduct oversight to ensure that State survey agencies are correctly referring abuse cases to law enforcement. Should Congress legislate a solution, and if so, what legislative language would you recommend to ensure GAO's recommendation is implemented adequately?

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[2] GAO, *Nursing Homes: CMS Needs Milestones and Timelines to Ensure Goals for the Five-Star Quality Rating System Are Met,* GAO–12–390 (Washington, DC: March 23, 2019).

[3] GAO, *Nursing Home Quality: CMS Should Continue to Improve Data and Oversight,* GAO–16–33 (Washington, DC: October 30, 2015). GAO, *Nursing Homes: Consumers Could Benefit From Improvements to the Nursing Home Compare Website and Five-Star Quality Rating System,* GAO–17–61 (Washington, DC: November 18, 2016).

[4] GAO, *Management Report: CMS Needs to Address Gaps in Federal Oversight of Nursing Home Abuse Investigations That Persisted in Oregon for at Least 15 Years,* GAO–19–313R (Washington, DC: April 15, 2019).

Answer. GAO recommended in its June 2019 report that CMS change its policy to require State survey agencies to immediately refer complaints and surveys to law enforcement (and, when applicable, to Medicaid Fraud Control Units, or MFCUs) if they have a reasonable suspicion that a crime against a resident has occurred when the complaint is received and conduct oversight of these referrals. This requirement would be in line with current Federal law, which requires covered individuals to immediately report reasonable suspicions of a crime against a resident that results in serious bodily injury to law enforcement and the State survey agency.[5] CMS concurred with these recommendations.

In a podcast released in late July, CMS addressed the issue of State surveyors reporting abuse and indicated that CMS is "working to clarify expectations about when abuse must be reported to the State and law enforcement. What this means is setting very clear and assertive timelines for agencies to review any allegations of abuse and neglect. And State survey—state surveyors actually, if a nursing home has not reported a clear incident of abuse or neglect, the surveyor must report that to law enforcement."

GAO will continue to follow up with CMS and track their progress on GAO's recommendation, which at this point has not been acted on by CMS. CMS has not indicated that it requires additional statutory authority to address this recommendation, though GAO defers to Congress on the extent to which this change could be made through congressional action.

Question. You indicated that there's some confusion about what is needed to substantiate an allegation of abuse. Which, if any, terms cited in statute or regulations lack sufficient clarity, and to what extent should CMS or Congress update regulatory or statutory definitions to promote greater clarity?

Answer. In its June 2019 report, GAO identified confusion among some State survey agencies about CMS's definition of what it means to substantiate an allegation of abuse. Two of the five State survey agencies in GAO's review told us they believed they could not substantiate an allegation unless they could also cite a Federal deficiency. This is inconsistent with CMS's guidance, which says that State survey agencies can substantiate that an allegation occurred without citing a Federal deficiency. GAO recommended that CMS develop guidance for State survey agencies clarifying that allegations verified by evidence should be substantiated and reported to law enforcement and State registries in cases where citing a Federal deficiency may not be appropriate, and CMS concurred with that recommendation.

Question. What specific legislative language do you suggest Congress adopt to ensure that CMS adopts GAO's open recommendations in the area of nursing home oversight?

Answer. GAO appreciates the chairman's interest in encouraging CMS to adopt GAO's recommendations that have not yet been acted upon. GAO will also continue to follow up on the status of open recommendations.

QUESTIONS SUBMITTED BY HON. JOHN THUNE

Question. In GAO's report, it lists four entities, in addition to State survey agencies, that may be involved with investigating abuse in nursing homes. Do these agencies communicate with one another and the State surveyor to share information that could be of value in preventing abuse?

Answer. In its June 2019 report, GAO found challenges in this area. Specifically, stakeholders in some of the States in GAO's review said that having multiple agencies involved in investigations can create challenges, including coordinating investigations and notifying one another about investigation outcomes.[6] One stakeholder said they sometimes begin an investigation without realizing another investigatory agency has already started its own investigation. Further, stakeholders in some of the five States in GAO's review said that CMS does not allow State survey agencies to share important investigatory information with law enforcement without a writ-

[5] 42 U.S.C. § 1320b–25(b). These covered individuals include nursing home owners, operators, and employees, among others.

[6] In addition to State survey agencies, which contract with CMS to ensure nursing home residents are free from abuse, other State-based agencies are charged with protecting nursing home residents from abuse. These agencies' roles, missions, and standards of evidence for determining whether or not abuse occurred can vary by State.

ten request.[7] For example, officials from one State survey agency said that they cannot share the name of the resident abuse or the time when the incident occurred, information that is key to a law enforcement investigation.

GAO's review of CMS's guidance on State survey agency referrals to law enforcement found that the guidance does not specify what information can be shared with local law enforcement, either in response to local law enforcement's request for information or when the State survey agency refers substantiated findings of abuse to law enforcement.[8] As noted above, both State survey and law enforcement agencies expressed confusion and frustration about what information can be shared and said delays have occurred that can impede law enforcement investigations. GAO recommended that CMS provide guidance on what information should be contained in the referral of abuse allegations to law enforcement. HHS concurred with GAO's recommendation and said it would develop a list of standardized elements that should be included when reporting an abuse allegation to law enforcement.

Question. What are the most significant factors contributing to underreporting of abuse? How can that be addressed?

Answer. GAO noted in its June 2019 report that abuse in nursing homes is often underreported by residents, family, and staff according to stakeholders GAO interviewed. Specifically, stakeholder groups in each of the five States GAO reviewed identified underreporting of abuse as a key challenge because investigators are unable to investigate if they do not know that abuse occurred. Both residents and their families may fail to report abuse because they may feel uncomfortable or fear retaliation from nursing home staff. A fear of retaliation can also extend to nursing home staff, who may be afraid to report abuse because they fear that they will lose their jobs or face retaliation from co-workers. In addition, abuse may be underreported because residents who are cognitively impaired may have difficulty recalling an incident of abuse and therefore may not be able to describe what happened. Further, if nursing homes have insufficient or inadequately trained staff, or if residents do not have family that visit frequently, warning signs of abuse may go unnoticed and, therefore, not reported. Addressing the issues identified, such as having sufficient and well-trained staff, could help to address some of the underreporting.

Question. Has GAO looked at nursing home closures and the factors that contribute to closure?

Answer. It has been several years since GAO examined the factors that contribute to nursing home closures. In a 2007 report on Federal nursing home enforcement, GAO found that nursing homes can close for several reasons, including as a result of lost income due to involuntary termination from participation in Medicare and Medicaid, which is one of several enforcement actions available to CMS when nursing homes are cited with deficiencies.[9] GAO found that two of the 63 nursing homes in GAO's review involuntarily closed because they were terminated by CMS from participating in Medicare and Medicaid. GAO reported that nursing homes were terminated by CMS infrequently because of CMS's concerns about access to other sources of nursing home care and the impact of moving residents to new homes. GAO also found that nine of the 63 nursing homes in GAO's review closed voluntarily, meaning they chose to close. CMS classified in its data the reasons a nursing home may voluntarily close as "merger/closure," "dissatisfaction with reimbursement," "risk of involuntary termination," or "other reasons for withdrawal." GAO found that these reasons for voluntary closure, as recorded by CMS, were general and did not always reflect that homes may have had histories of harming residents that put them at risk of involuntary termination. For example, some homes may voluntarily close to avoid involuntary termination from CMS due to quality problems cited by State surveyors.

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[7] HHS regulations implementing the Privacy Act provide that disclosure of information to another governmental entity is permitted "for a civil or criminal law enforcement activity if the activity is authorized by law, and if the head of such [governmental entity] has submitted a written request to the Department [of Health and Human Services] specifying the record desired and the law enforcement activity for which the record is sought" (45 CFR § 5b.9(b)(7)) (2018).

[8] State survey agencies are required to report substantiated findings of abuse to local law enforcement and MFCUs, if appropriate. State Operations Manual, Complaint Procedures, § 5330, Revision 155, June 10, 2016, CMS.

[9] GAO, *Nursing Homes: Efforts to Strengthen Federal Enforcement Have Not Deterred Some Homes From Repeatedly Harming Residents,* GAO–07–241 (Washington, DC, March 26, 2007).

QUESTIONS SUBMITTED BY HON. ROBERT MENENDEZ

Question. During the hearing, I asked about the possibility of creating a unified reporting system that requires immediate reporting by the nursing homes into a platform that would simultaneously send those cases to CMS, law enforcement, and State agencies. Further, I asked about potential barriers to unifying a reporting system, not only for abuse cases but to better track and weed out staff who have histories of abusive behavior. At the hearing you stated that you had not examined the type of common reporting system that I mentioned.

Now that you've had more time to consider the proposal, can you outline potential barriers to unifying a reporting system?

Answer. While GAO made recommendations in the June 2019 report that CMS require State survey agencies to make more immediate referrals to law enforcement and conduct oversight of these referrals, GAO did not evaluate the tools that CMS could use to do so. In its comments, HHS concurred with GAO's recommendations and noted that it would consider how to implement mechanisms for tracking these law enforcement referrals.

Question. Would such a system reduce delays and better flag potential abuse cases?

Answer. As noted above, GAO has not examined the advantages and disadvantages of this type of system in its body of work.

Question. During the hearing, two reasons were presented to explain why more States who participated in the National Background Check Program (NBCP) did not successfully implement the required range of background checks: States' inability to pass necessary legislation and the need for increased funding to ensure appropriate infrastructure is in place at the State level.

Has OIG or GAO identified key barriers to States passing necessary legislation?

Answer. GAO has not conducted work specific to the National Background Check Program and has not identified key barriers to States passing necessary legislation. However, GAO's June 2019 report noted the importance of more background screening of staff. Specifically, stakeholders GAO interviewed in three of the five States said that inadequate staff screening can be a risk factor for abuse. Because staff screening through background checks and the nurse aide registry is not coordinated across the country, there are gaps that could enable individuals who committed crimes in one State to obtain employment at a nursing home in another State, a concern that GAO previously reported.[10]

CMS requires nursing homes to establish policies that prevent the hiring of individuals who have been convicted of abusing nursing home residents, but does not require that they conduct background checks—either statewide or nationally. States, however, may require that background checks be conducted. CMS also requires nursing homes to check the State nurse aide registry before hiring a prospective nurse aide to ensure there is not a finding of abuse. However, nurse aide registries only reflect an aide's history in a particular State. And although there are multi-State registry verification requirements, including that nursing homes seek information from every State registry in States where they believe the aide has worked, GAO has raised concerns about State nurse aide registries.

Question. Is there action Congress can take to incentivize States to pass legislation that would enable the program to be implemented?

Answer. As noted above, GAO has not conducted work specific to the National Background Check Program.

Question. On average, how much funding would a State need in order to ensure that the appropriate infrastructure was in place?

Answer. As noted above, GAO has not conducted work specific to the National Background Check Program.

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[10] GAO, *Nursing Homes: More Can Be Done to Protect Residents From Abuse,* GAO–02–312 (Washington, DC: March 1, 2002).

QUESTIONS SUBMITTED BY HON. SHELDON WHITEHOUSE

Question. Today's GAO report finds that abuse deficiencies cited in nursing homes have more than doubled since 2013, and that CMS has many gaps in its oversight of these facilities. These are disturbing findings, and I am pleased to see GAO made recommendations for how CMS can improve its oversight.

When can we expect to see CMS implementation of these recommendations?

Answer. GAO's June 2019 report made six recommendations and HHS concurred with each recommendation. According to CMS officials, they anticipate taking actions on these recommendations by the end of 2019. In addition, GAO made three recommendations in an April 2019 report on gaps in Federal oversight of nursing home abuse investigations in Oregon. HHS also concurred with each recommendation, and CMS officials said they anticipate taking actions on these recommendations by late 2019 or early 2020.

Question. Does GAO have any additional recommendations for improved oversight that would require congressional action?

Answer. In addition to the recommendations described above, GAO has recommendations for improving nursing home oversight from past reports that CMS has not yet implemented. Specifically, in a 2016 report on the Five-Star System, GAO recommended that CMS add information to the Five-Star System that allows homes to be compared nationally, but HHS did not concur with this recommendation and it remains open.[11] Two recommendations from GAO's 2015 report on nursing home quality that HHS concurred with also remain open, including that CMS should implement a clear plan for ongoing auditing of self-reported data and establish a process for monitoring oversight modifications to better assess their effects.[12] GAO's 2011 report examining oversight of complaint investigations has six recommendations that HHS concurred with that also remain open, including that CMS improve the reliability of its complaints database and clarify guidance for its State performance standards.[13]

GAO defers to Congress on whether these recommendations require congressional action.

PREPARED STATEMENT OF HON. CHUCK GRASSLEY,
A U.S. SENATOR FROM IOWA

Today we'll focus on an issue that has affected many families in Iowa and throughout the country: elder justice. Congress has a key role to play in ensuring the protection of our Nation's seniors, as about one in 10 Americans age 60 or older will fall victim to elder abuse each year.

Many older Americans reside in assisted care facilities, nursing homes, or other kinds of group living arrangements. It's critical that these care facilities and staff not only follow the law, but provide the type of care they would want their own family members to receive.

The Government Accountability Office just released a new report on this subject today, while the Inspector General at the Department of Health and Human Services issued a related report on this topic last month. According to the Inspector General, one-third of nursing home residents may experience harm while under the care of these facilities. In more than half of these cases, the harm was preventable. We look forward to hearing both agencies' recommendations for Congress at today's hearing.

In the 115th Congress, I introduced the Elder Abuse Prevention and Prosecution Act, which was enacted unanimously. It enhances enforcement against perpetrators of crimes targeting older Americans. Specifically, it increases training for Federal investigators and prosecutors and designates at least one prosecutor in each Federal judicial district be tasked with handling cases of elder abuse. The law also increases

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[11] GAO, *Nursing Homes: Consumers Could Benefit From Improvements to the Nursing Home Compare Website and Five-Star Quality Rating System,* GAO–17–61 (Washington, DC: November 18, 2016).

[12] GAO, *Nursing Home Quality: CMS Should Continue to Improve Data and Oversight,* GAO–16–33 (Washington, DC: October 30, 2015).

[13] GAO, *Nursing Homes: More Reliable Data and Consistent Guidance Would Improve CMS Oversight of State Complaint Investigations,* GAO–11–280 (Washington, DC: April 7, 2011).

penalties for perpetrators of abuse and ensures that the Federal Trade Commission's Bureau of Consumer Protection and the Department of Justice (DOJ) have an elder justice coordinator.

It's now important that we consider the need to reauthorize the Elder Justice Act. Years ago, I joined my colleagues, led by former Chairman Hatch, in developing an early version of the Elder Justice Act, which was adopted in 2010. It is time for this committee to update and extend the key programs authorized under this important law, which authorized the Elder Justice Coordinating Council and resources to support forensic centers to investigate elder abuse, among other initiatives. I am working closely with the members of the Elder Justice Coalition, whose leader is testifying today, on legislation to accomplish that goal. This new legislation will call for training of long-term care ombudsmen, resources for elder abuse forensic centers, among other provisions.

The Des Moines Register last year published reports suggesting a troubling lack of compassionate care for elder residents in some of the nursing homes in my State. Reports also surfaced in 2017 of nursing home workers in at least 18 different facilities taking humiliating, unauthorized photos of elderly residents and posting them on social media websites.

In March, this committee convened an oversight hearing at which we heard from the daughters of two elderly women who resided in federally funded nursing homes. One testified that her mother, an Iowan, died due to neglect, in a facility that held the highest possible rating, five stars, on a Federal Government website. The family discovered that the nursing home was the subject of multiple complaint investigations in recent years. Yet after each complaint, government inspectors reported that the facility had come back "into substantial compliance with program requirements." Another witness testified about her mother's rape in a nursing home. Many nursing homes offer excellent care, but these and similar cases around the country point to the need for greater oversight.

Families facing the decision to put a loved one in a care facility or nursing home deserve to have reliable tools to help make the best choice possible. They shouldn't have to worry that their loved one will be abused at the hands of a caregiver. I look forward to hearing from all of our witnesses on what more Congress can do to help ensure that government-provided information on nursing homes and care facilities is accurate and reliable, and that oversight efforts will continue to increase quality standards and keep them high.

PREPARED STATEMENT OF HON. MARK PARKINSON, PRESIDENT AND CHIEF EXECUTIVE OFFICER, AMERICAN HEALTH CARE ASSOCIATION

Chairman Grassley, Ranking Member Wyden, and distinguished members of the Senate Finance Committee (committee), thank you for holding this important hearing. My name is Mark Parkinson, and I am proud to be the President and CEO of the American Health Care Association (AHCA), a position that I have held since 2011. On behalf of AHCA and its members, I would like to thank the committee for the opportunity to participate in this morning's hearing, "Promoting Elder Justice: A Call for Reform." I would also like to formally thank the thousands of men and women who every day provide excellent, high quality care to nursing home residents across this great Nation.

As a former nursing home owner, former governor of the great State of Kansas, and now as President and CEO of AHCA, I have and continue to commit my career to improving care for the elderly. I would like to begin my testimony by stating clearly and unequivocally that abuse and neglect have no place in the nursing home setting and no place in any health care setting.

AHCA is the Nation's largest association of long term and post-acute care providers, representing nearly 10,000 of the 15,000 plus nursing homes in the country who routinely provide high-quality care to nearly 4 million individuals each year. We represent nearly half of all not-for-profit facilities, two-thirds of proprietary skilled nursing facilities (nursing homes), and half of all government facilities.

Our mission is improving lives by delivering solutions for quality care. While there are troubling stories and reports like those that have been testified to today, it is imperative that we remember there are also countless accounts of nursing home staff providing high quality resident care for days, weeks, and even years.

THE QUALITY INITIATIVE AND IMPROVEMENTS MADE

In early 2012, AHCA launched a multi-year national effort to further improve the quality of care in America's skilled nursing care centers through our Quality Initiative (Initiative). The profession's ongoing efforts have improved the lives of the individuals AHCA members serve while also reducing health care costs. In 2018, we rolled out the next phase of the Initiative to include measurable 3-year targets in key areas such as hospitalizations and antipsychotic usage. The effort aligns with Federal mandates for quality performance and outcomes and continues to challenge providers to achieve quantitative results in four areas by March 2021. Progress is measured by the Centers for Medicare and Medicaid Services (CMS) reporting measures endorsed by the National Quality Forum. We have targeted improvements in lowering hospitalizations, increasing customer satisfaction, improved functional outcomes and continued decreases in the use of antipsychotics. AHCA provides tools and support to help providers make improvements in these areas.

I take great pride in quality improvements we have made in nursing homes across the country. In the last 7 years, both the quality of care and caregiving methods used in our nursing homes have improved dramatically. Together, we must build off this success to address some of the complex challenges faced by the nursing home community.

It bears repeating from the March 2019 hearing that over the past 7 years, nursing homes have demonstrated improvement in 18 of the 24 quality outcomes measured and publicly reported by CMS. Let me elaborate.

- **Fewer residents are returning to the hospital from the nursing home.** An important measure of nursing home quality is the number of residents who return to a hospital because their condition has deteriorated during their nursing home stay. Today, that indicator of quality has changed for the better. AHCA used the all-payor measure to calculate the number of residents returning to the hospital after a nursing home stay has declined 11.6 percent since 2011.
- **Fewer residents are receiving antipsychotic medications.** Today, less than one in seven nursing home residents are receiving antipsychotic medications. This is a significant decline from 2011, when one in four residents received an antipsychotic.
- **Staff are spending more time than ever before with residents.** Prior to the Five-Star updates earlier this year, it was remarkable to see that 75 percent of nursing homes received three out of five stars or better from CMS for staffing. In fact, in 2018, three out of every four nursing homes had *more* registered nurses and clinical staff caring for residents than what CMS projects they should have based on the type of residents in the facility. This is a significant improvement, even compared to just 2 years ago when 18 percent had staff greater than what CMS expected based on the facility's residents. At the same time, as described below, we are facing serious staffing challenges.
- **Nursing homes provide more person-centered care today than ever before.** Only one in 18 nursing home residents report experiencing pain compared to one in eight in 2011. Moreover, since 2011, common ailments among nursing home residents have steadily declined. In fact, we can document a 20 percent decrease in pressure ulcers, a 61 percent decline in urinary tract infections, and a 35 percent decline in depressive symptoms.

This is good news as we continue to train staff to better understand and care for residents with dementia without medications and replace antipsychotic medications with robust activity programs, social workers, and resident councils so that residents can be mentally, physically, and socially engaged.

Senators, we need your help. The nursing home community neither fears accountability nor oversight. It does fear that those opportunities for improvement in nursing home care across the country are stymied by factors outside of its control.

PROPOSALS MADE

Today, I do not intend to defend the incidents of poor care that have occurred; they should not happen. Rather, consistent with our mission, I offer some solutions to prevent such incidents from happening in the future.

I would like to report that subsequent to the March 2019 hearing on nursing homes, AHCA prepared and submitted a detailed letter to the committee outlining

solutions that will improve the quality of care in America's nursing homes. AHCA set forth for the committee some actionable items that can be implemented right now.

Subsequent to that letter, AHCA staff met with committee staff members to discuss potential legislation to reform and improve the operation of nursing homes. In response to that meeting, AHCA provided committee staff with detailed information intended to complement the committee's interests in reducing abuse and neglect in, among other venues, nursing homes.

In other words, Senators, we are at the table, we are active, we are engaged, and most importantly, we are prepared to support reforms that will continue to improve the lives of America's elderly.

Our May 7, 2019 letter to the committee details AHCA's recommendations to improve quality care in America's nursing homes.

First, AHCA specifically noted that it is imperative for follow-up surveys conducted by CMS, which investigates abuse allegations and conducts inspections to confirm the existence or non-existence of abuse allegations, to be completed more quickly. This is good common sense. Indeed, if there is abuse, CMS should want to capture it quickly rather than allow a situation to fester. The nursing home community agrees.

Next, it is AHCA's position that one of the root causes for many of the incidents cited by CMS for neglect frequently lies in part with a nursing home's ability to hire, engage, and retain skilled, talented, and suitable staff to care for this frail and vulnerable population. Unfortunately, and as AHCA testified earlier, there is a national workforce shortage, which is even worse in the rural areas. We need your help; we cannot solve this problem alone. We are thinking creatively about solutions, such as a loan forgiveness program. At the same time, and as reported by the Medicare Payment Advisory Commission in 2018, nursing homes have no extra room to increase costs compared to the reimbursements they receive from Medicaid and Medicare—which cover three-fourths of residents in nursing homes.

We are also in desperate need of a stronger process to prevent people who are at risk of inflicting abuse or neglect from working in nursing homes. We have asked repeatedly for facilities to have access to the National Practitioner Data Bank so that we can better vet individuals before hiring them. No one—not you, not I, not anyone—wants sexual predators or those with tendencies to injure the frail to be employed by any nursing facility.

AHCA also continues to strongly support a mechanism for public reporting on resident and family satisfaction. Nursing homes are the only sector without a CMS reporting requirement on satisfaction. Making consumer satisfaction information available to families and future residents will go a long way towards enhancing transparency regarding the operation of a nursing home.

Now, I would like to briefly address the June 2019 Office of Inspector's General Report (OIG). The OIG prepared a series of reports addressing the identification, reporting, and investigation of incidents of potential abuse. First, in its report entitled *Incidents of Potential Abuse and Neglect at Skilled Nursing Facilities Were Not Always Reported and Investigated* (Report) the OIG determined that among Medicare beneficiaries sent to the emergency room (ER) from the nursing home "one in five high-risk hospital ER Medicare claims for treatment provided in calendar year 2016 were the result of abuse or neglect, injury of unknown source, of beneficiaries residing in a SNF." The OIG report then went on to say that nursing homes failed to report many of these and that survey agencies themselves also frequently failed to report findings of abuse to local law enforcement. Of the 51 ER claims reviewed, the State agency was not aware of 43. This by reference means that neither the nursing home *nor* the hospital ER or physicians reported these cases. Lastly, the OIG found that CMS itself "does not require all incidents of potential abuse or neglect and related referrals made to law enforcement and other agencies to be recorded and tracked in" the appropriate tracking system the agency maintains.

The OIG also looked at all ER visits with suspected abuse and neglect. It found that of the 34,664 claims associated with incidents of potential abuse or neglect, 7.4 percent were allegedly perpetrated by a health care worker, 9.6 percent were related to incidents that occurred in a medical facility, and 27 percent were related to incidents not reported to law enforcement. In most of the cases (64 of 94), the abuse occurred in the Medicare beneficiary's home, while 16 cases occurred in other peo-

ples' homes or public settings. Furthermore, 12 occurred in a medical facility; and of those, only seven occurred in a nursing home.

One of the most important aspects of this report is the fact that the OIG highlighted a matter of critical importance to the nursing home community and one that has been a topic of discussion for quite some time. Specifically, the report on page 12 noted that the nursing homes, interviewed in response to why some incidents were not reported, stated that "CMS guidance was *not clear* and therefore, the SNFs interpreted it inconsistently." They did not try to hide these cases; instead, they did not believe the cases met the CMS definition so they did not need to report them. It was not due to lack of awareness that education will correct but confusion as to the CMS definition and reporting requirements. Interestingly, the OIG report goes on to State that even the survey agency officials across States have different interpretations of the term "suspicious." Ultimately, the OIG concludes that, "The lack of clear guidance from CMS results in incidents going unreported by the SNFs."

We can take this lack of clarity one step further. The definition of abuse as outlined in the Elder Justice Act (Act) differs from that in nursing home regulations. The Act also mandated timely reporting by nursing homes of suspected abuse but not in other settings; this causes confusion. The Elder Justice Act needs to require that CMS and other agencies use the same definition of abuse and neglect, separate them in enforcement and tracking, and standardize the reporting guidelines (including time to report) for all health-care settings to be consistent.

Members of the committee, I implore you again, on behalf of AHCA, that CMS be directed to clarify once and for all the definition of abuse and neglect and ensure that those same definitions and reporting standards are consistent across all health-care settings. Otherwise, we cannot effectively tackle this problem.

Because AHCA was not privy to the contents of the report issued by the U.S. Government Accountability Office (GAO) prior to preparation of this statement I will, with the committee's permission, augment my written testimony later to ensure that there is a complete record.

CONCLUSION

AHCA remains committed in its efforts to strive for complete elimination of all instances of abuse and neglect. We will continue working with this committee and others to achieve that goal. But again, we need your help to implement changes that will help prevent and perhaps even one day eliminate incidents of abuse and neglect.

Members of the committee: our passion, our commitment, and our goal are to challenge ourselves to improve and enhance quality for all residents in both the short and long term.

The entire nursing home profession stands ready to continue working with Congress, members of this committee, CMS, and other health care providers to enhance its mission to improve lives by delivering solutions for quality care. Thank you for the opportunity to testify today, and I look forward to answering your questions.

QUESTIONS SUBMITTED FOR THE RECORD TO HON. MARK PARKINSON

QUESTIONS SUBMITTED BY HON. CHUCK GRASSLEY

Question. Can you tell the committee whether you train your members, through AHCA's Quality Initiative, about how to recognize and report suspected crimes, like sexual abuse or exploitation, of nursing home residents?

Answer. AHCA has devoted significant resources to training our members about abuse and neglect reporting requirements. Shortly after the Elder Justice Act passed, AHCA developed a website[1] that provided members with template policy and procedures as well as forms for reporting to the State Survey Agency and local law enforcement agencies along with letters. We promoted this to our membership and offered training webinars. We shared the documents with CMS prior to disseminating them to ensure we included the correct information. We took a similar ap-

[1] *See* AHCA website on Elder Justice Act, *https://www.ahcancal.org/facility_operations/affordablecareact/Pages/Elder-Justice-Act.aspx*.

proach when CMS issued the guidance on limiting the use of social media postings of pictures and other recordings without resident consent.[2]

In 2016, we worked with each of our State affiliates[3] to conduct full day intensive workshops about the new CMS regulations, including the new definitions on abuse and neglect and the reporting requirements. We provided additional resources and tools, as well as a summary of these trainings, via our on-line learning management system *ahcancalED*.

Finally, we provide educational sessions at our annual and spring conferences on the topic of abuse and neglect, and many of our State affiliates have conducted similar training at their State conferences as well.

The challenge, though, is due to the confusion we hear from our members around the definition of abuse and neglect, and how CMS operationalizes the definition. Our members are acutely aware of the written reporting requirements and time frames.

However, CMS's lack of clear guidance and lack of consistency in applying the definitions make providers unclear on what to report. Providers receive conflicting guidance from surveyors in different States and regions, and the citations issued vary for nearly identical situations. In addition, CMS does not define abuse or neglect in regulations for most all other Medicare providers, including hospitals and home health. Many of the physicians, nurses and other health professionals who provide care in nursing homes also work in other settings and they often express surprise or confusion that certain incidents in nursing homes need to be reported or result in citations for abuse or neglect, when in other settings they are never cited nor reported. The OIG reported similar confusion in their June 2019 report entitled *Incidents of Potential Abuse and Neglect at Skilled Nursing Facilities Were Not Always Reported and Investigated.*[4] This is also confusing for State survey agencies as they must keep track of multiple definitions and reporting requirements for all settings. Thus, for any training to be effective, all healthcare providers and health professionals must be held to the same definition and reporting requirements.

Question. Do we know how many of your members have reported suspected crimes at skilled nursing facilities to State survey agencies in the last year? Do you think State licensing agencies do an adequate job of following up on these reports, and if not, what more might we do to ensure that reports are investigated promptly?

Answer. Current Medicare and Medicaid regulations require facilities to self-report potential allegations of abuse or neglect to the State Survey Agency. CMS labels these as self-reported incidents as complaints and aggregates them along with consumer complaints and other anonymous complaints. As a result, most "complaints" represent self-reported incidents. Last year there were approximately 200,000 complaints submitted to State Survey Agencies.[5] Approximately one in five of these complaints are classified by CMS and the State Survey Agency as either abuse or neglect. Of the 41,098 abuse or neglect complaints reported in this time frame, most (80 percent) were *not* substantiated. Of the 8,457 complaints that were substantiated and resulted in some type of citation, only about one-third were cited for abuse or neglect (2,563). Of those, the majority (75 percent) were *not* related to any harm. In other words, of the 200,000 complaints submitted to CMS and the State last year, only 629 (or 0.3 percent) resulted in a citation for abuse or neglect that was associated with some form or harm. While any number is too high, this demonstrates that the reporting guidance from CMS is confusing and results in over-reporting.

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[2] *See* AHCA guidance on use of social media and use of pictures and recordings, *https://www.ahcancal.org/facility_operations/legal_resources/Documents/2016%20Social%20Media%20Guidance.pdf.*

[3] AHCA has a State affiliate in every State except Montana, where SNFs can join AHCA through their members in adjoining States. AHCA currently represents approximately 10,000 of the 15,000 SNFs in the country including nearly half of not-for-profit and government-owned facilities and about two-thirds of for-profit facilities, the majority of which are small family-owned buildings.

[4] In this study, the OIG found that many cases of abuse and neglect were not reported by the facility. However, since many of the cases were not in the State files nor in local law enforcement files, this indicates that ER personnel and hospital workers also did not report these cases. In addition, the State survey personnel often failed to report as well.

[5] Data from CMS CASPER data files from 2018 quarter 1 through 2019 quarter 1.

The data is not much better when one restricts those complaints reported to CMS that are prioritized by CMS and the State Survey Agency as potentially representing an Immediate Jeopardy (IJ) situation.[6] Upon intake, about 10 percent of abuse or neglect complaints were prioritized as a possible immediate jeopardy. Most of these complaints (~80 percent) were unsubstantiated upon further investigation and only 246 (6 percent) were cited for abuse or neglect at a scope and severity of IJ. In other words, the prioritization approach CMS uses results the survey agency conducting 100 inspections they label as high priority to identify only 6 as being substantiated last year.

Many of these self-reported incidents are not investigated until the State Survey Agency visits the facility for their annual inspection (which occur per statute every nine to 15 months). Those classified as representing potential immediate jeopardy are to be investigated by the State agency onsite within two business days of notification. This often does not happen. The OIG and GAO examined the actual time it takes to investigate complaints and self-reported incidents, as compared to CMS policies and procedures. While over two-thirds of all complaints and self-reported incidents are not found to represent non-compliance with regulations (*e.g.,* do not result in a citation), the timeliness of these investigations, which CMS requires to be done within two to 10 days of reviving the report for serious incidents, varies considerably. The OIG found that almost one-quarter of States did not meet CMS's performance threshold for timely on-site investigations of high priority complaints in 5 years.[7]

Further complicating the timeliness of investigating complaints is the variation in what needs to be reported in each State. CMS guidance species the minimum reporting requirements that SNFs must meet in all States, but also gives each State the authority to add additional requirements. Some States have expanded the list of reportable incidents considerably, which has increased their workload and ability to perform timely follow-up visits. A GAO report found variation in how States collect, investigate and report complaints, making comparability difficult. This also may explain the increase in complaints over time.[8] See Figure 1 below illustrating that while the number of complaints have increased over time, the number that are substantiated has not increased. Another reason for the delay in follow-up visits is the enormous number of reports that are not substantiated. The large number is due to both the overly broad definitions used and operationalized by CMS, as well as the variation in citations and enforcement. As a result, providers often over-report to ensure they are meeting the requirements. The increasing penalties associated with failing to report has further increased the number of reports. More reporting requirements or penalties will only further swamp State agency and local law enforcement resources. Better and more consistent application of the definition is needed.

Using CMS data, we examined the time to conduct follow-up inspections to verify the deficiency was corrected. Once a facility receives a citation, the survey agency requires a plan of correction to be submitted within 10 days and for citations related to actual harm or likelihood of causing further serious harm, they require a revisit by the State agency. The time for revisits has averaged 40–50 days and is longer for citations with actual harm (citations rated as G or higher) compared to those not associated with any harm (citations rates as F or lower). Figure 2 shows the average time for revisits based off CMS data posed on their website. As the severity of the deficiency increases, the time to revise to assure correction also increases.

CMS needs to clarify the complaint and self-reporting program and standardize the reporting criteria in all States. If States want to investigate additional complaints under State licensing authority, that should not be co-mingled with the CMS Federal system as it adds confusion, increase workload to the State and makes the data between States not comparable.

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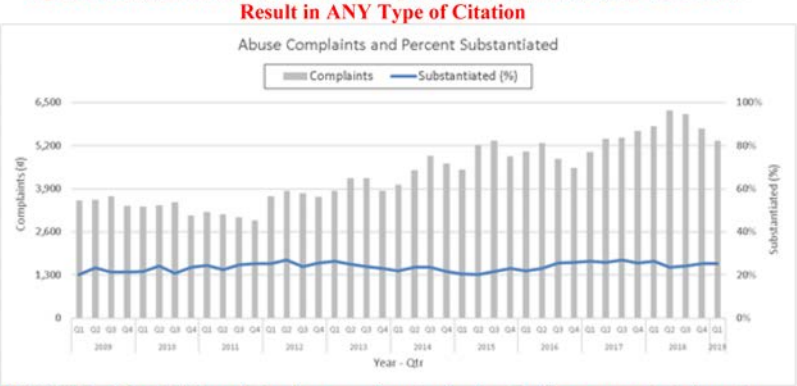
[6] An Immediate Jeopardy (IJ) is defined as a situation in which there is an immediate likelihood of serious harm. It is the most serious type of potential deficiency.

[7] "A Few States Fell Short in Timely Investigation of the Most Serious Nursing Home Complaints: 2011–2015." HHS OIG Data Brief, September 2017, OEI–01–16–00330, *https://oig.hhs.gov/oei/reports/oei-01-16-00330.pdf*.

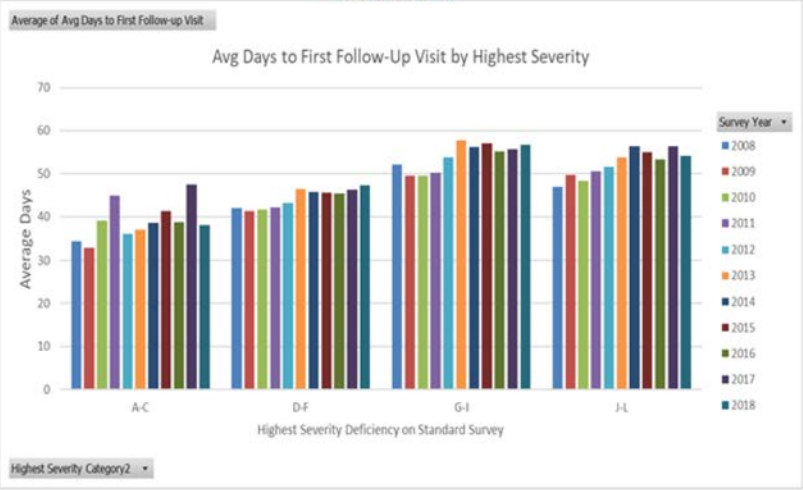
[8] "Nursing Home Quality: Continued Improvements Needed in CMS's Data and Oversight." Testimony before the Subcommittee on Oversight and Investigations, Committee on Energy and Commerce, House of Representatives. Statement of John E. Dicken, Director, Health Care. GAO–18–694Tb, Thursday, September 6, 2018, *https://www.gao.gov/assets/700/694324.pdf*.

Figure 1. Historical Trends in Facility Reports of Potential Abuse to CMS That Result in ANY Type of Citation



NOTE: Of the 20% or 8,457 complaints that were substantiated and resulted in some type of citation, only about one-third were cited for abuse or neglect (n = 2,563). Of those, the majority (75%) were NOT related to any harm. In other words, only 629 (or 0.3% of all complaints or 7.4% of substantiated complaints) resulted in a citation for abuse or neglect that was associated with some form or harm.

Figure 2. Average Days for CMS to Conduct Follow-up Visits to Verify a Citation Was Corrected



Question. What percentage of your members run background checks of potential employees? Of what do these checks consist? (For example, how many of your members use in-State fingerprint checks, where data from only one State is used? What percentage rely on nationwide fingerprint checks, or nationwide name checks?) Are there members who don't do checks at all, and do you believe they should be required to perform some sort of checks as a condition of participation in Medicare or Medicaid? Do you have legislative recommendations for Congress in this area?

Answer. All nursing homes run some type of background check as its required in order to comply with the CMS regulations. CMS regulations require that nursing homes not employ or otherwise engage individuals who: (1) have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (2) have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (3) have a disciplinary action in effect against his or her profes-

sional license by a State licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.

It is unclear how many conduct national fingerprint checks or nationwide checks. While the Federal regulations do not explicitly require fingerprint-based background checks, according to CMS guidance, facilities must be thorough in their investigations of the histories of prospective staff. A thorough investigation requires a variety of checks. State licensure laws typically specify various checks in addition to a fingerprint-based checks, such as State criminal history, sex offender and other abuse registries, and nurse aide registries. Many of our members go beyond the CMS requirements by conducting monthly checks of the national OIG List of Excluded Individuals and Entities, checking State police records from surrounding States, repeating the background check for existing employees at specified time intervals (*e.g.,* 2 years), and conducting drug screening. As of Fiscal Year 2018, 27 States, Puerto Rico and the District of Columbia had applied to participate in the National Background Check Program that was enacted by the Patient Protection and Affordable Care Act. In exchange for funding, these States are supposed to require nursing homes to conduct four types of background checks: (1) search of State-based abuse and neglect registries and databases (*e.g.,* nurse aide registries) in the States where they previously lived; (2) check of State criminal history records; (3) fingerprint-based check of FBI criminal history records; and (4) search of the records of any proceedings in the State that may contain disqualifying information.

The most recent Office of Inspector General (OIG) report indicates that participating States have achieved varying levels of implementation (OEI–07–10–00160). To date the National Background Check Program has not resulted in a comprehensive new data source for providers to conduct more effective background checks.

Moreover, much of the abuse in nursing homes happens from staff without a State or Federal criminal record, but they may have other types of records that could be red flags of potential problems. Alternatively, the staff may not disclose States where they have a record. It is also not feasible for nursing homes to individually query all 50 State nurse aide registries, licensing boards, and State civil judgment data bases. That represents more than 150 unique searches that would need to be conducted prior to each staff hire, with an application fee often required for each database.

Therefore, AHCA has recommended that providers be granted access to the National Practitioner Data Bank (NPDB) maintained by HRSA. The NPDB contains information from all 50 States in a single database. It also contains additional information from hospitals and other providers who have terminated a health professional on staff for abuse. Information is submitted by (among other required reporters): all State licensure and certification boards; hospitals that have terminated a provider for abuse; State and Federal law enforcement agencies on health care-related civil judgments; State and Federal law enforcement agencies on health care-related criminal convictions; and OIG exclusions.

Access to the NPDB would be a significant step toward helping long-term care providers more effectively and efficiently screen potential employees for histories of disciplinary problems from all 50 State licensing boards and any prior terminations for abuse.

We believe a fingerprint-based approach to background checks is costlier and less efficient than using the NPDB, which is why we recommend allowing nursing homes easier access to this resource.

First, giving access to the NPDB is a better solution because the relevant information can be more efficiently and effectively obtained through the NPDB. One check of the NPDB would yield nearly all the information that would be found through an FBI fingerprint background check, as well as substantially more information related to other State criminal activities and any licensure actions in any State and exclusions from the OIG list. HRSA reports that the NPDB includes Federal and State health care-related civil judgments and criminal convictions, as well State licensing board adverse findings. In contrast, the FBI search may not include civil judgments or information from State licensing boards and registries, only Federal or State criminal convictions.

Second, fingerprint checks are expensive, which creates a barrier to hiring staff, when they can get jobs in other health-care settings without needing a fingerprint check. The fee for searching the NPDB is $2 per query. In contrast requesting an FBI background check is at least $18. State fingerprint checks and other databases often have a fee as well. Although some providers cover the cost of fingerprint

checks, not all do so, and they must shift the cost to the prospective employee who may not be able to afford the search.

Third, fingerprinting through the FBI can take substantial time both for the prospective hire to travel to an approved location to obtain fingerprints during limited business hours and for the results of the query to return. Nursing homes report waiting weeks for results from the FBI, which is a hardship during this severe workforce shortage. Often employees accept positions at other providers such as hospitals that don't require FBI fingerprint checks. A 2015 Government Accountability Office report details challenges with FBI criminal history record checks for individuals working with vulnerable populations, including delays and gaps in the information provided (GAO–15–162).

Question. You testified that we need to do a better job of defining the term "abuse." Should we amend the statutory definition of "abuse" or related terms used to identify abuse, neglect, or exploitation in skilled nursing facilities? What specific definitions might CMS adopt to reduce ambiguity in these terms, and how do we ensure that nursing home personnel as well as State and Federal nursing home inspectors are adequately trained to readily spot the signs of abuse or neglect?

Answer. The statutory definition of abuse and neglect are defined in the Elder Justice Act. The definitions don't necessarily need to be redefined; however, CMS has defined them differently in their regulations, and haven't defined abuse and neglect at all in most other setting's regulations. Table 1 shows the variation in definition, reporting requirements and enforcement penalties across the different Medicare providers. Guidance is needed to standardize the definition, reporting requirements and penalties across settings. Without consistency, there is confusion. For example, the OIG found in their recent report[9] that many cases of abuse or neglect were not reported to the State Survey Agency or local law enforcement. The report focuses on the failure of the nursing home to report, but implicit in their finding was the failure of the physicians, emergency room staff and hospital to also report cases. This clearly demonstrates confusion on reporting and why different requirements result in cases of potential abuse involving the elderly not being appropriately investigated.

With respect to neglect, the definition is currently written so that operationalizing it can result in overly broad application. The definition is "the failure of a caregiver or fiduciary to provide the goods or services that are necessary to maintain the health or safety of an elder."[10] As such, one-time episodes of not providing care (*e.g.,* forgetting to administer a medication on time, failing to reposition a resident, not washing one's hands) would constitute neglect. While all the above examples are problems that should be corrected, and often represent poor quality, how CMS and State agencies apply the definition of neglect to them varies. Some survey agencies and CMS regional offices will interpret the neglect definition as any one instance of not delivering care, while others do not. Not only does this contribute to confusion on reporting, it exacerbates the workforce shortage in nursing homes. Many nurses will not risk being accused of neglect, which triggers them being suspended pending an investigation and being reported to their licensure board (all of which must be disclosed on any future job applications), when the same incidences are not treated as neglect in other settings such as the hospital or home health. We would recommend that guidance be provided to CMS that the definition of neglect should also include some component of time and frequency with respect to the failure to provide services. Regardless, the definition needs to be operationalized and enforced the same in all settings.

[9] *Incidents of Potential Abuse and Neglect at Skilled Nursing Facilities Were Not Always Reported and Investigated, https://oig.hhs.gov/oas/reports/region1/11600509.pdf.*

[10] *https://www.ssa.gov/OP_Home/ssact/title20/2011.htm.*

Table 1. Regulations and Interpretive Guidelines (IG) Containing Definitions of Abuse and Neglect and Requiring Reporting to CMS

Setting	Regs contain resident/patient right to be free from abuse and neglect	Regs define abuse	Regs define neglect	Regs require reporting allegations of abuse and neglect	IGs define abuse	IGs define neglect	IGs require reporting allegations of abuse and neglect[11]
Skilled Nursing Facilities (SNF)	YES	YES	YES	YES	YES	YES	YES
Hospitals[12]	YES	NO	NO	NO	YES	YES	YES
Psychiatric Hospitals	NO	NO	NO	NO	NO	NO	NO
Long-Term Care Hospitals (LTCH)	YES	NO	NO	NO	YES	YES	YES
Critical Access Hospitals (CAH)[13]	NO	NO	NO	NO	NO	NO	NO
Home Health Agencies (HHA)	YES	NO	NO	YES[14]	YES	YES	YES
In-Patient Rehabilitation Facilities (IRF)	YES	NO	NO	NO	YES	YES	YES
Transplant Centers	YES	NO	NO	NO	YES	YES	YES

Question. Should there be more consistency in how State inspections are conducted in each State, so that we can get a better picture of how any given nursing home compares to others across the country? If so, what could Congress or CMS do to promote such consistency?

[11] Interpretive guidance on reporting various across setting. For hospitals, as well as LTCHs, IRFs, and transplant centers that must meet the hospital conditions of participation, the obligation to report is only addressed in survey guidelines that direct surveyors to assess whether appropriate agencies are notified in accordance with State and Federal laws regarding incidents of substantiated abuse and neglect.

[12] Swing beds in hospitals must meet the requirements for freedom from abuse, neglect, and exploitation as outlined in § 483.12 (the SNF requirements of participation).

[13] Swing beds in CAHs must meet the requirements for freedom from abuse, neglect, and exploitation as outlined in § 483.12 (the SNF requirements of participation).

[14] HHA staff who "in the normal course of providing services" identify, notice, or recognize incidences or circumstances of mistreatment, neglect, verbal, mental, sexual, and/or physical abuse, including injuries of unknown source, or misappropriation of patient property, must report these findings immediately to the HHA and other appropriate authorities in accordance with State law.

Answer. While all State Survey Agencies utilize the same inspection protocols and base citations on the same regulations and sub-regulatory guidance,[15] there are enormous variations in the number, severity and enforcement actions between States and CMS regional offices. CMS publishes the number of citations, the scope and severity of citations and enforcement actions by State and CMS region on their QCOR website. This data shows large variations in citations and enforcement actions across the 10 CMS regional offices which are unrelated to the quality in the region. We have summarized that variation by CMS region in Table 2 below. For example, the average number of citations varies more than 4-fold from a low of 3.6 in Region II to 14.5 in Region X. In Region IV, for example, the average number of citations per facility is less than the national average (5.2 vs 8.0 per facility); but the total CMPs fines are 2.3 times larger than the rest of the Nation ($23M vs $10M nationally). Yet, Region IV's quality is nearly identical to the other nine regions (50 percent of facilities in Region IV achieved an overall rating of four or five stars compared to the national average of 49 percent; and rehospitalization rates are only slightly higher on average than the national average (22.6 percent vs 21.6 percent)).

The scope and severity of citations also vary across regions as shown in Table 3. The proportion of citations classified as Immediate Jeopardy vary nine-fold, ranging from 0.6 percent to 4.6 percent, yet there is nowhere near that level of variation in staffing levels or other quality outcomes. CMS needs to monitor the reliability and consistency of citations across regions and States, by examining how similar incidents are cited. The purpose of the survey process is to assure that residents are receiving the care they need to achieve the best possible outcomes. The effectiveness of the survey process should not be measured by the number or severity of citations handed out but should be judged on the outcomes related to resident quality of life and quality of care.

Table 2. Variation in CMS Regional Office Citations and Enforcement Compared to Quality in CY 2018

Region	Active SNFs	# of Residents in SNFs	Avg # Citations	% SNF w/ Any Penalty	% w/ Any DPNA	% SNFs w/ CMPs	Total CMP ($)	Avg Per Diem CMP	Overall Five Star Rating at 4 or 5	Avg 30 Day Rehospitalization Rate 2018
(I) Boston	926	84,396	6.6	22%	0.8%	25%	$5,428,556	$48,115	58%	22.9%
(II) New York	993	147,252	3.6	10%	0.5%	13%	$2,636,001	$64,733	57%	21.1%
(III) Philadelphia	1,402	143,316	10.5	15%	2.9%	16%	$13,399,473	$127,109	49%	21.4%
(IV) Atlanta	2,716	246,770	5.2	15%	3.3%	20%	$23,648,085	$84,772	50%	22.6%
(V) Chicago	3,476	265,125	9.0	20%	5.2%	21%	$23,723,794	$65,457	51%	22.6%
(VI) Dallas	2,158	160,061	7.8	18%	6.1%	21%	$13,211,333	$67,900	34%	24.1%
(VII) Kansas City	1,519	89,423	7.3	14%	6.6%	13%	$4,733,133	$43,616	51%	21.8%
(VIII) Denver	636	39,900	6.5	21%	2.4%	14%	$3,998,229	$82,429	61%	18.7%
(IX) San Francisco	1,460	120,749	12.1	12%	2.8%	12%	$4,578,655	$101,619	58%	22.3%
(X) Seattle	459	28,052	14.5	38%	1.3%	51%	$5,856,518	$41,572	60%	18.9%
National Total	15,745	1,325,044	8.0	17%	3.9%	19%	$101,213,778	$71,356	49%	21.6%

Table 3. Variation in CMS Regional Office Scope and Severity of Citations in CY 2018

	Deficiencies by Scope & Severity CY 2018														
Region	B	C	D	E	F	G	H	I	J	K	L	Total	Active SNFs	average # citations	% Citations >J
(I) Boston	276	130	3,995	1,112	175	330	13	0	59	18	0	6,108	926	6.6	1.3%
(II) New York	116	34	2,604	661	120	65	0	0	16	3	5	3,624	993	3.6	0.7%
(III) Philadelphia	370	551	9,366	3,459	554	326	12	1	49	24	8	14,720	1,402	10.5	0.6%
(IV) Atlanta	144	302	9,785	2,062	789	331	5	0	471	160	17	14,066	2,716	5.2	4.6%
(V) Chicago	194	836	21,412	4,824	2,359	1,305	13	1	242	72	29	31,287	3,476	9.0	1.1%
(VI) Dallas	273	358	3,549	9,506	2,015	325	129	6	174	341	62	16,738	2,158	7.8	3.4%
(VII) Kansas City	124	321	6,144	3,019	1,045	339	19	2	103	34	13	11,163	1,519	7.3	1.3%
(VIII) Denver	26	50	2,441	1,246	152	182	15	1	13	11	2	4,139	636	6.5	0.6%
(IX) San Francisco	508	63	11,852	4,217	534	386	7	1	21	25	33	17,647	1,460	12.1	0.4%
(X) Seattle	26	381	3,975	1,424	273	416	21	0	57	50	14	6,637	459	14.5	1.8%
National Total	2,057	3,026	75,123	31,530	8,016	4,005	234	12	1,205	738	183	126,129	15,745	8.0	1.7%

Data source: Based on Data from CMS QCOR website downloaded in May 2019.

Question. I understand that an adequate workforce is the most pressing issue for many skilled nursing facilities. Can you elaborate on this challenge for your members and suggest solutions, other than just more taxpayer funding, to help meet these workforce shortages, especially in rural areas?

[15] Sub-regulatory guidance operationalizing the nursing home Requirements of Participation regulations are spelled out in the State Operating Manual—in appendix PP—at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf*.

Answer. The lack of an adequate workforce is a pressing concern for skilled nursing centers and assisted living communities across the country. A study by the Department of Health and Human Services (HHS) and the Department of Labor (DOL) estimates that the U.S. will need between 5.7 million and 6.5 million nurses, nurse aides, home health, and personal care workers to care for the 27 million Americans who will require long term care in 2050. AHCA hears daily from its members on the challenges of finding staff to fill their open positions, both nursing and support services. The issue of the workforce shortage is multi-faceted, but some of the key issues compounding the problem include:

- **CNA revocation:** A key enforcement action used by State Survey Agencies is to revoke CNA training programs. However, if there's no access to training at a skilled nursing facility, potential employees will go elsewhere to get training. This will likely impact rural SNFs more frequently as there are less employers in the area and a more pronounced access to qualified staff.
- **Recruitment/retention:** Long-term care organizations compete against other professions that can pay higher wages as they can readily increase prices to absorb the wage increase since they are not as dependent on State Medicaid rates, which have been shown to pay less than cost. In addition, the skilled nursing facility regulatory burden, detailed below, has a negative impact on recruitment efforts.
- **Nursing shortage:** The nursing shortage is well-documented in this country. The shortage is compounded by the fact that many nurses do not want to work in our field due to the regulatory burden described below.
- **Regulatory burden:** Many health-care workers will not work in long-term care because the reporting requirements and enforcement actions CMS places on nursing centers put staff at greater risk for loss of their professional licenses or subject them to individual suspensions or fines for occurrences that would be defined in another setting as an accident or error, but are defined as abuse or neglect in nursing center regulations and guidance. This exacerbates the workforce shortages in nursing centers.
- **Background checks:** See the response above regarding the challenges of conducting adequate background checks.

There is not just one solution to this workforce shortage. AHCA has invested in the development tools, resources and training programs to help members effectively recruit new staff and retain existing staff. AHCA has also identified and supported several programs and initiatives to get more workers in the long-term care field, including:

- The Health Profession Opportunity Grants (HPOG). This program currently funds demonstration projects in 22 States to help Temporary Assistance for Needy Families (TANF) recipients and other low-income individuals acquire skills, gain employment, and advance up the career ladder in health professions.
- Increasing opportunities for employers to utilize workers from other countries including increasing H2–B visas and paths to citizenship for "dreamers," many of which are working in the health-care field.
- Additional slots in nursing schools addressing this with programs like Geriatrics Academic Career Awards (GACA) through HRSA. This is a complement to the Geriatrics Workforce Enhancement Program (GWEP). Both programs are included in the title VII reauthorization bill, the EMPOWER for Health Act of 2019 (H.R. 2781) and the geriatrics title VIII reauthorization bill, the Geriatrics Workforce Improvement Act (S. 299).
- Ensuring Federal loan forgiveness programs are maintained and expanded, when possible to cover long term care providers. For example, the Loan Forgiveness Nursing Where It's Needed (Nursing WIN) Act expands the authority of the Secretary of Health and Human Services to permit nurses to practice in health-care facilities with critical shortages of nurses through programs for loan repayment and scholarships for nurses. HRSA defines critical shortages facilities as: "a health-care site located in a Health Professional Shortage Area (HPSA) that provides primary medical care or mental health care to underserved populations. Health Professional Shortage Areas are designated by the Health Resources and Services Administration and are used to identify areas, population groups, or facilities within the United States that

are experiencing a shortage of health professionals." This definition could be too narrow to include a number of long-term care providers.

- Pushing for regulatory relief through the Patients Over Paperwork initiative. Staff can use their time more efficiently and effectively if they can spend more time at the bedside, rather than on paperwork.

There is not one solution to this pressing issue, but through creative and wide-ranging solutions, AHCA hopes to ease the burden of this workforce shortage from our members and to help ensure that residents have the adequate staff needed to achieve their best possible outcomes.

Question. What changes, if any, should we make to improve the Nursing Home Compare website or the government's Five-Star Rating System for nursing homes?

Answer. The Nursing Home Compare (NHC) website and Five-Star Rating System, while not perfect, do provide consumers with information to help locate nursing homes in their community as well as information to help make decisions. The NHC website provides information on survey inspections along with copies of the citation reports and summary of the citation's descriptions. For example, consumers can currently click on the citation reports to see if a facility has any citations for abuse and neglect and what type of citation they received (see Figure 3 screen shot of NHC website with abuse and neglect citations). Staffing levels along with star ratings of those levels and comparisons to the national average are posted. Clinical outcomes that are calculated by CMS from either Medicare Claims or the electronic medical record are also reported for outcomes related to those in the facility for short term rehabilitation after a hospital stay as well as outcomes for residents who are living in the facility—defined as those in the facility for more than 100 days.

Figure 3. Screen Shot of Nursing Home Compare with Survey Inspection Findings Highlighted

Print all information

Nursing home profile

Back to Results

General information | Health inspections | Fire safety inspections | Staffing | Quality of resident care | Penalties

ACCORDIUS HEALTH AT ST MARY, LLC

Overall rating: ★●●●●
Much Below Average

Health inspections

This page of Nursing Home Compare reports information about a nursing home's health inspections, complaints files and any resulting citations. Nursing homes that are certified by Medicare and Medicaid are inspected each year. Health care professionals inspect each nursing home and look for any health and safety citations. Learn more.

The health inspection star rating is based on each active provider's current health inspection survey and the 2 prior surveys, as well as findings from the most recent 3 years of complaints information and inspection revisits.

	ACCORDIUS HEALTH AT ST MARY, LLC
Health Inspection rating	★●●●● Much Below Average
Date of most recent health inspection	08/16/2018 View full report
Total number of health citations	9
Average number of health citations in Iowa	5.4
Average number of health citations in the U.S.	8.0
Date(s) of complaint inspection(s) between 7/1/2018 - 6/30/2019	08/16/2018 View full report
Number of complaints in the past 3 years that resulted in a citation	16
Number of times in the past 3 years a facility-reported issue resulted in a citation	0
View all health inspection details	View all health inspection, complaint, and facility-reported issue details

There are two key areas missing from Five-Star that AHCA would strongly advocate be included. The first is information directly from the consumer, such as customer satisfaction ratings. Customer satisfaction is measured and reported by CMS for all other settings except for nursing homes. This is a glaring gap. We would strongly recommend that CMS add customer satisfaction to the NHC website. The second is staffing, turnover and retention metrics, which AHCA has included in our Quality Initiative. Turnover and retention are important indicators of quality for any facility, and consumers should be able to access this information when making decisions about where to place their loved ones.

Question. What changes, if any, do you recommend that Congress make to the Elder Justice Act? Please identify any concerns with activities authorized under that statute, such as training for the long-term care ombudsman program, funding for Adult Protective Services activities, or the Elder Justice Advisory Council.

Answer. Congress can improve the protection of vulnerable seniors by eliminating discrepancies across Medicare provider settings in how abuse and neglect are defined, the provider reporting requirements, and the penalties. The definitions of abuse and neglect should be the same in all Medicare settings; abuse is abuse whether it occurs in the home, a hospital, or a nursing center. However, the current definitions of abuse and neglect vary across health care settings and for many provider settings, are not defined in regulation by CMS. For example, neither acute

care hospitals nor critical access hospitals have a definition of abuse or neglect in regulations (other than for swing beds for SNF care, for which regulations mirror those for SNFs). Home health agencies only have a definition of abuse in interpretative guidance but do not have definitions of abuse or neglect in regulation. When abuse or neglect is defined in sub-regulatory interpretative guidance for these various settings, the definitions also vary.

Further, abuse and neglect should not be classified and counted in the same way, particularly given how CMS currently defines neglect for SNFs. The June 2019 OIG report found that only 1–2 percent of the neglect of nursing home residents sent to the emergency room was classified as abuse, while 98 percent was classified as due to neglect. By citing abuse and neglect within the same F-tag for SNFs, the difference between what is abuse and what is neglect for purposes of enforcement and public reporting is obscured. Abuse is commonly the result of individual bad actor, while neglect (poor care) is more often the result of systematic issues at the nursing center. The enforcement and action taken needs to be tailored more appropriately to the situation to ensure improvement and prevention.

The requirements for reporting allegations of abuse and neglect to CMS (via the State Survey Agency) and to local law enforcement also vary, as do enforcement procedures for instances of abuse or neglect. Although instances or types of abuse or neglect may vary across settings due to differences is patient characteristics, care needs, or other variables, the fundamental definitions, reporting requirements, and seriousness of enforcement should be consistent regardless of setting. For example, a finding that a staff person intentionally struck a patient or resident should be defined as an instance of physical abuse regardless of the setting in which it occurred.

The variation in defining, reporting and enforcing violations of abuse and neglect creates confusion for providers and health-care professionals such as registered nurses and certified nursing assistants, as well as for law enforcement, consumers, and the public as they make decisions about their own health care and that of their loved ones. It also makes it more difficult for nursing centers to recruit and retain the most qualified health-care workers. Many health-care workers will not work in long-term care because the reporting requirements and enforcement actions CMS places on nursing centers put staff at greater risk for loss of their professional licenses or subject them to individual suspensions or fines for occurrences that would be defined in another setting as an accident or error, but are defined as abuse or neglect in nursing center regulations and guidance. This exacerbates the workforce shortages in nursing centers, which increases the risk of poor quality of care and closures we heard about in the prior SFC hearing and as reported in *The New York Times* on March 4, 2019.[16]

QUESTIONS SUBMITTED BY HON. JOHN THUNE

Question. GAO's report identified nursing home staffing characteristics that could increase risk for abuse in facilities, such as insufficient staff and inadequate training on abuse. In many rural areas, limited staff and resources are significant challenges. What strategies have your members identified to help overcome these challenges? Are there Federal policies that prevent implementation of these strategies?

Answer. The workforce shortage has hit rural providers even harder than others. The issue of the workforce shortage is multi-faceted, but some of the key issues compounding the problem include:

- **CNA revocation:** A key enforcement action used by State Survey Agencies is to revoke CNA training programs. However, if there's no access to training at a skilled nursing facility, potential employees will go elsewhere to get training. This will likely impact rural SNFs more frequently as there are less employers in the area and a more pronounced access to qualified staff.
- **Recruitment/retention:** Long-term care organizations compete against other professions that can pay higher wages as they can readily increase prices to absorb the wage increase since they are not as dependent on State Medicaid rates, which have been shown to pay less than cost. In addition, the skilled nursing facility regulatory burden, detailed below, has a negative impact on recruitment efforts.

[16] *https://www.nytimes.com/2019/03/04/us/rural-nursing-homes-closure.html.*

- **Nursing shortage:** The nursing shortage is well-documented in this country. The shortage is compounded by the fact that many nurses do not want to work in our field due to the regulatory burden described below.
- **Regulatory burden:** Many health-care workers will not work in long-term care because the reporting requirements and enforcement actions CMS places on nursing centers put staff at greater risk for loss of their professional licenses or subject them to individual suspensions or fines for occurrences that would be defined in another setting as an accident or error, but are defined as abuse or neglect in nursing center regulations and guidance. This exacerbates the workforce shortages in nursing centers.
- **Background checks:** See the response above regarding the challenges of conducting adequate background checks.

There is not one solution to this workforce shortage. AHCA has invested in the development tools, resources and training programs to help members effectively recruit new staff and retain existing staff. AHCA has also identified and supported several programs and initiatives to get more workers in the long-term care field, including:

- The Health Profession Opportunity Grants (HPOG). This program currently funds demonstration projects in 22 States to help TANF (Temporary Assistance for Needy Families) recipients and other low-income individuals acquire skills, gain employment, and advance up the career ladder in health professions.
- Increasing opportunities for employers to utilize workers from other countries including increasing H2–B visas and paths to citizenship for "dreamers," many of which are working in the health-care field.
- Additional slots in nursing schools—addressing this with programs like Geriatrics Academic Career Awards (GACA) through HRSA. This is a complement to the Geriatrics Workforce Enhancement Program (GWEP). Both programs are included in the title VII reauthorization bill, the EMPOWER for Health Act of 2019 (H.R. 2781) and the geriatrics title VIII reauthorization bill, the Geriatrics Workforce Improvement Act (S. 299).
- Ensuring Federal loan forgiveness programs are maintained and expanded, when possible to cover long term care providers. For example, the Loan Forgiveness Nursing Where It's Needed (Nursing WIN) Act expands the authority of the Secretary of Health and Human Services to permit nurses to practice in health care facilities with critical shortages of nurses through programs for loan repayment and scholarships for nurses. HRSA defines critical shortages facilities as: "a health-care site located in a Health Professional Shortage Area (HPSA) that provides primary medical care or mental health care to underserved populations. Health Professional Shortage Areas are designated by the Health Resources and Services Administration and are used to identify areas, population groups, or facilities within the United States that are experiencing a shortage of health professionals." This definition could be too narrow to include a number of long-term care providers.
- Pushing for regulatory relief through the patients over paperwork initiative. Staff can use their time more efficiently and effectively if they can spend more time at the bedside, rather than on paperwork.

There is not one solution to this pressing issue, but through creative and wide-ranging solutions, AHCA hopes to ease the burden of this workforce shortage from our members and to help ensure that residents have the adequate staff needed to achieve their best possible outcomes.

Question. As part of its Patients Over Paperwork initiative, CMS has proposed policies that aim to reduce administrative burdens on nursing homes. It appears that the hope would be for facilities to be able to dedicate more resources to resident care. If finalized, how would facilities ensure that quality is not sacrificed, especially when GAO tells us we need better data?

Answer. On June 16th, CMS issued a proposed rule with changes to the Requirements of Participation for nursing centers and skilled nursing centers. These changes are designed to eliminate unnecessary and duplicative paperwork and allow caregivers to devote more time and resources to resident care. The proposed modifications were focused almost exclusively on changes to administrative and paperwork sections of the new requirements. These changes target only the most burden-

some requirements that only hinder a facilities ability to deliver of high-quality care. For example, CMS is proposing to reduce burdensome paperwork requirements.

- Example: Facilities would only be required to send copies of resident discharge notices to the State LTC Ombudsman when the *facility* has initiated the transfer or discharge. Currently, facilities must do this even when a *resident* has elected to transfer to another facility or is ready to be discharged back home or to the community.
- Example: CMS has proposed to reduce the time frame that facilities are required to retain posted daily staffing data from 18 months to 15 months (or as required by State law).

In many instances, CMS has not removed requirements but simply clarified where one requirement may be used to meet a requirement in a different area. Rather than eliminating requirements, they are simply clarifying where similar requirements do not need to be duplicated.

- Example: Under the administration section, CMS clarifies that facility assessment data can be used to inform policies and procedures for other LTC requirements.

The changes proposed uphold the numerous provisions and core principles of the regulations to ensure all residents receive quality care. CMS has retained all resident rights, including the right to be free from abuse and neglect, and has upheld key standards for resident care including resident assessment, person-centered care planning, infection control and antibiotic stewardship, quality of life, and quality of care requirements. The important new provisions in the original rule, of which AHCA supported, remain, including: abuse and neglect; safe drug prescribing; infection control; antibiotic stewardship; better care planning; and expanding program integrity/corporate compliance programs.

These changes should ultimately improve the quality of care provided by facilities, as it will allow more time to be spent on patient care and less on burdensome and unnecessary requirements.

QUESTIONS SUBMITTED BY HON. TIM SCOTT

Question. This is a deeply important topic, particularly as our population continues to age. According to Census projections, in 11 years, one in every five Americans will be retirement-age. And by 2035, for the first time in U.S. history, older Americans will outnumber those under age 18. Given these seismic changes, as well as the fact that roughly 70 percent of older Americans will need long-term care at some point, the core mission and work of our Nation's nursing homes have never been more essential. It seems clear that the vast majority of facilities are doing everything in their power to meet the needs of our seniors, as well as the other vulnerable populations that they serve. We have nearly 190 nursing homes in South Carolina, and having visited many of them—and engaged with the residents and patients, as well as the folks who work tirelessly, day-in and day-out, to provide the care that they deserve—I can attest to the great work that is so often done on the ground. Even after the recent changes to the CMS star rating system, close to half of our facilities have four or five stars overall, and a sizable majority have at least three.

That said, placing loved ones or friends in a home can be an incredibly difficult decision, and when you hear stories of abuse and neglect, however rare, they make those choices even harder.

I think it's imperative that we seek out strategies for identifying and addressing these issues where they occur, without imposing top-down mandates or administrative burdens that ultimately divert attention away from patient and resident care. I was pleased, along those lines, to see CMS's proposal from earlier this month, which would streamline and better target the Requirements of Participation for nursing facilities, to the tune of $616 million a year in cost savings for facilities. Those savings will free up resources for innovations and reforms that will make a meaningful impact in our seniors' lives. Governor Parkinson, I see the potential reauthorization of the Elder Justice Act as a welcome opportunity to discuss targeted avenues for reform.

As we think through ways to enhance the Elder Justice Act, putting aside the issue of funding levels, are there particular areas where the legislation is working well, or where it could use some improvements or clarifications?

Answer. Congress can improve the protection of vulnerable seniors by eliminating the discrepancy across Medicare provider settings in how abuse and neglect are defined, the provider reporting requirements, and the penalties. The definitions of abuse and neglect should be the same in all Medicare settings; abuse is abuse whether it occurs in the home, a hospital, or a nursing center. However, the current definitions of abuse and neglect vary across health care settings and for many provider settings, are not defined in regulation by CMS. For example, neither acute care hospitals nor critical access hospitals have a definition of abuse or neglect in regulations (other than for swing beds for SNF care, for which regulations mirror those for SNFs). Home health agencies only have a definition of abuse in interpretative guidance but do not have definitions of abuse or neglect in regulation. When abuse or neglect is defined in sub-regulatory interpretative guidance for these various settings, the definitions also vary.

Question. When looking specifically at the allowable uses for the grants and other funding streams authorized by the legislation, are there new flexibilities or points of clarification that would be helpful in efforts to support our seniors?

Answer. Ensuring access to grants or other funding streams that can support recruitment, retention and training initiatives in long term care and defining the long term care facility to ensure it encompasses the entire sector would be helpful. This should include the promotion of opportunities to providers to easily access funding streams designed for providers and the use of Civil and Monetary Penalty money to support innovative programs.

Question. In addressing the issue of workforce recruitment, training, retention, and quality enhancement, for instance, how could we work within the Elder Justice Act framework to promote efforts along these lines?

Answer. AHCA has four suggestions that would help promote efforts along these lines: promotion of programs to providers and ease in accessing or applying to funding streams; providing support or documents outlining how to apply for grants; allowing for a quick turnaround for review of applications and receipt of funding; and alleviating any overly burdensome paperwork that is a barrier to accessing grants.

Question. I have spoken at length with Administrator Verma about CMS's recent efforts and initiatives with regards to nursing homes, and I am grateful for her commitment to prioritizing this area, particularly in light of the regulatory relief provided in the agency's most recent proposed rule.

When surveying the administrative activity of the past few years with regards to nursing homes, which proposals, final rules, and other initiatives do you see as most helpful in terms of addressing the needs of our seniors, combating cases of abuse and neglect, and ensuring that facilities have the tools, capacity, and flexibilities needed to support our seniors and other vulnerable populations?

Answer. There are a few areas where CMS's administrative efforts in the last several years have taken strides to ensure facilities have the tools, capacity, and flexibilities needed to support our seniors and other vulnerable populations residing in nursing centers. CMS's efforts to improve transparency and put patients over paperwork by removing excessively burdensome paperwork requirements and enabling providers to spend more time on resident care have benefits for both providers and nursing center residents. The changes CMS has included in its proposed rule revising the Requirements of Participation are an important step in achieving this goal. Other examples of helpful initiatives include:

- CMS has made electronic surveyor training materials available to providers via an online website accessible to providers and the public. This helps to create a framework for shared knowledge and understanding of CMS regulations and guidance and promotes openness and transparency.
- CMS has also made data on survey citations and remedies available to providers and the public through its QCOR website and has indicated a willingness to make additional survey and certification data available. Such efforts promote transparency and provide a foundation for CMS and stakeholders to identify and address shared concerns.
- CMS has also made efforts to develop new training materials for providers to support compliance and meet the needs of the changing nursing center pop-

ulation through trainings such as Hand in Hand: A Training Series for Nursing Homes. Certified nurse aides working in nursing centers must receive training on caring for residents with dementia and on abuse prevention. The CMS Hand in Hand training was designed to provide nursing homes with a training program on person-centered care for persons with dementia and abuse prevention taught by subject matter experts and those with experience providing this type of care. What made this training useful was its emphasis on practical application and real-world examples. Providers and residents benefit from such practical resources supported and disseminated by CMS.

Question. Along those same lines, where is there room for improvement in terms of administrative efforts over the same period?

Answer. In line with the helpful initiatives highlighted above, there are further opportunities for CMS to improve transparency and support the delivery of high-quality care. For example: CMS should continue to promote and expand opportunities for sharing training materials and shared training opportunities with surveyors and providers to understand regulations and guidance and support sustained compliance. A foundation of shared knowledge of the regulatory requirements and CMS expectations and guidance is critical for ensuring a fair, consistent, and effective survey process.

- CMS should remove duplicate quality measures. There are 56 quality measures currently in use in skilled nursing and long-term care centers. In addition to the significant volume of quality measures which is overwhelming, there are multiple measures being used for the same care areas. Two examples of this are rehospitalization and discharge to community, which each have duplicative measures in use. Quality measurement should be laser focused on what is most meaningful to patients or residents and most informative to providers on improving quality of care. At a minimum, duplicate measures should be removed from use.
- CMS should create more opportunities for providers and key stakeholders to address common goals of promoting high quality care and resident outcomes, such as through quarterly meetings to discuss effective approaches and best practices to issues such as the opioid crisis and how to care for residents with behavioral health and substance abuse issues.
- Congress should create additional flexibility for CMS to engage in pilot projects to test effective approaches and best practices to emerging challenges such as the growing nursing center population with behavioral health and substance abuse issues. CMS should also engage in pilot projects to test new approaches to improving the transparency and consistency of the survey process.
- Congress should mandate that CMS standardize definitions of abuse and neglect across Medicare-funded settings. Definitions of abuse and neglect should be the same in all settings; abuse is abuse whether it occurs in the home, a hospital, or a nursing center. Variation causes confusion as well as complexity in the process that results in unnecessary administrative burden and can adversely affect appropriate abuse and neglect reporting. According to the CDC (taken from the CDC website dated May 28, 2019): "A consistent definition is needed to monitor the incidence of elder abuse and examine trends over time. Consistency helps to determine the magnitude of elder abuse and enables comparisons of the problem across locations. This ultimately informs prevention and intervention efforts."
- CMS should also clarify the differences between abuse and neglect by separating abuse and neglect in tracking and enforcement actions and, for purposes of tracking and enforcement, delineating when abuse occurs between residents, from staff to resident, from family member or other parties, or other forms to help the public better understand what is happening and help guide more targeted interventions to prevent abuse. Lumping abuse and neglect together causes confusion as the response and actions may differ with abuse related to criminal investigation versus neglect related to system and quality of care issues. The approach and response would be more efficient if tracked and reported separately. Similarly, the type of abuse (*e.g.,* resident to resident, physical, etc.) should also be tracked and reported separately to help make more efficient use of resources and response options.
- CMS should also change Payroll-Based Journal (PBJ) policy to be consistent with Department of Labor rules. Current PBJ policy requires mandatory ex-

clusion of 30 minutes from every 8-hour shift worked for meals or break time, regardless of whether a staff member actually took a meal break or not. This mandatory exclusion does not allow for times when staff work through their meal break or provide care for more than eight hours without a meal break. Staffing hours are inaccurately and underreported due to the PBJ policy mandatory exclusion. This forced exclusion by PBJ policy imposes unnecessary administrative burden because it requires nursing centers to perform timekeeping for PBJ purposes separate from timekeeping for payroll purposes for Department of Labor and actual payroll to staff. PBJ policy should be updated to eliminate the mandatory exclusion of 30 minutes from every 8-hour shift and allow for consistency with Department of Labor rules.

Question. Setting aside the issue of authorization levels, are there legislative opportunities, whether in the Elder Justice Act or elsewhere, to build upon what's working and to provide fixes to areas for growth?

Answer. Yes, there are several opportunities to build on effective strategies and provide new opportunities for growth. Examples include:

- In regard to the Elder Justice Act, we must ensure access to grants or other funding streams that can support recruitment, retention and training initiatives in long-term care. Defining long-term care facility to ensure it encompasses the entire sector. Any initiatives that can ease burden of accessing and applying for grant monies including quick turnaround for review of grants and awarding of the funding.
- Currently the Elder Justice Act, has requirements for abuse and neglect reporting and penalties that only apply to nursing homes. Also, CMS has only defined abuse and neglect and reporting requirements in nursing home regulations; not any other settings. The OIG report found that many cases of abuse and neglect presenting to the emergency room occur in other settings and that many are not reported to the State agency, local law enforcement or other agencies responsible for investigating abuse or neglect. The reporting requirements and penalties should be the same in all settings. Having different definitions, different reporting requirement and different penalties creates confusion resulting in cases not being reported. It also has the unintended effect of discouraging staff from working in nursing homes, just when we need more staff; because they can work in other settings without worry of reporting requirements or penalties. We support having the Elder Justice Act definitions, reporting requirements and penalties apply to all Medicare providers and professionals.
- Supporting programs such as the Health Profession Opportunity Grants (HPOG) and ensuring they include long-term care. This HPOG program currently funds demonstration projects in 22 States to help Temporary Assistance for Needy Families (TANF) recipients and other low-income individuals acquire skills, gain employment, and advance up the career ladder in health professions.
- Increasing opportunities for employers to utilize workers from other countries including increasing H2–B visas and paths to citizenship for "Dreamers," many of which are working in the health care field.
- Supporting additional slots in nursing schools through programs like Geriatrics Academic Career Awards (GACA) through HRSA. This is a complement to the Geriatrics Workforce Enhancement Program (GWEP). Both programs are included in the title VII reauthorization bill, the EMPOWER for Health Act of 2019 (H.R. 2781) and the geriatrics title VIII reauthorization bill, the Geriatrics Workforce Improvement Act (S. 299).
- Ensuring Federal loan forgiveness programs are maintained and expanded, when possible to cover long term care providers. For example, the Loan Forgiveness Nursing Where It's Needed (NursingWIN) Act expands the authority of the Secretary of Health and Human Services to permit nurses to practice in health-care facilities with critical shortages of nurses through programs for loan repayment and scholarships for nurses. HRSA defines critical shortages facilities as: "a health-care site located in a Health Professional Shortage Area (HPSA) that provides primary medical care or mental health care to underserved populations. Health Professional Shortage Areas are designated by the Health Resources and Services Administration and are used to identify areas, population groups, or facilities within the United States that are expe-

riencing a shortage of health professionals." This definition could be too narrow to include a number of long-term care providers.

Question. What steps could be taken to standardize the definition of abuse and neglect across all settings, and what resources could be provided to help Skilled Nursing Facility staff better investigate allegations of abuse or neglect?

Answer. As mentioned above, Congress should eliminate discrepancy across Medicare provider settings in the definition of abuse and neglect, in the provider reporting requirement and in enforcement penalties.

Abuse and neglect should be classified and counted in the same way in all settings to avoid confusion on reporting. Also, CMS needs to define abuse and neglect as defined in the elder just act, which they currently define differently in the nursing home regulations. In addition, the definition of neglect in the elder justice act needs to also take into consideration the frequency and extent of the failure to deliver services. CMS has operationalized this to mean any one instance regardless of it causing any harm. So any medication error, no matter how infrequent or insignificant, is a failure to deliver services and meets the definition of neglect. This results in large number of reports to the State and local law enforcement overwhelming the ability to investigate the serious cases of neglect resulting in harm.

Also, abuse and neglect need to be recorded, citated and reported separately. The June 2019 OIG report found that only one to two percent of the neglect of nursing home residents sent to the emergency room was classified as abuse, while 98 percent was classified as due to neglect. By citing abuse and neglect within the same F-tag for SNFs, the difference between what is abuse and what is neglect for purposes of enforcement and public reporting is obscured.

The requirements for reporting allegations of abuse and neglect to CMS (via the State agency) and to local law enforcement also currently vary and must be standardized, as do enforcement procedures for instances of abuse or neglect.

Question. Of the recommendations offered by the OIG and by GAO, which do you see as the most fruitful to pursue? What steps should we take to best operationalize the recommendations that would be most helpful to implement (insofar as they require or would benefit from legislative action)?

Answer. AHCA supports the recommendations made in the June 2019 OIG report entitled, *Incidents of Potential Abuse and Neglect at Skilled Nursing Facilities Were Not Always Reported and Investigated* and in the July 2019 GAO report entitled, *Improved Oversight Needed to Better Protect Residents From Abuse.* These recommendations are as follows:

OIG Report—Incidents of Potential Abuse and Neglect at Skilled Nursing Facilities Were Not Always Reported and Investigated: (1) work with the Survey Agencies to improve training for staff of SNFs on how to identify and report incidents of potential abuse or neglect of Medicare beneficiaries; (2) clarify guidance on how to clearly define and provide examples of incidents of potential abuse or neglect; (3) requiring the Survey Agencies to record and track all incidents of potential abuse or neglect in SNFs [need to separate abuse from neglect] and referrals made to local law enforcement and other agencies; and (4) monitoring the Survey Agencies' reporting of findings of substantiated abuse to local law enforcement.

GAO Report—Improved Oversight Needed to Better Protect Residents From Abuse: (1) require that abuse and perpetrator type be submitted by State survey agencies in CMS's databases for deficiency, complaint, and facility-reported incident data, and that CMS systematically assess trends in these data; (2) develop and disseminate guidance—including a standardized form—to all State survey agencies on the information nursing homes and covered individuals should include on facility-reported incidents; (3) require State survey agencies to immediately refer complaints and surveys to law enforcement (and, when applicable, to MFCUs) if they have a reasonable suspicion that a crime against a resident has occurred when the complaint is received; (4) conduct oversight of State survey agencies to ensure referrals of complaints, surveys, and substantiated incidents with reasonable suspicion of a crime are referred to law enforcement (and, when applicable, to MFCUs) in a timely fashion; (5) develop guidance for State survey agencies clarifying that allegations verified by evidence should be substantiated and reported to law enforcement and State registries in cases where citing a Federal deficiency may not be appropriate; and (6) provide guidance on what information should be contained in the referral of abuse allegations to law enforcement.

AHCA agrees that the recommendations made across the two reports would help to improve reporting, investigation and future prevention of instances and abuse and neglect. However, these recommendations will *only* be impactful if the following issues are addressed:

- Eliminate discrepancies across provider settings in how abuse and neglect are defined, specifically for nursing homes.
- Separating the reporting and citation of abuse and neglect to ensure appropriate enforcement and improvement actions.

The OIG and GAO reports indicate significant issues with the identification and reporting of abuse and neglect across settings. They concluded that there is real confusion among providers and regulators alike on the reporting guidelines due to different, unclear definitions and reporting guidance. OIG interviews confirmed that not only did SNFs fail to report due to confusion but due to the fact that the State Survey Agency or law enforcement were unaware of the cases, the hospital ER and physicians also failed to report these cases. There is a lack of consistent guidance on what constitutes abuse and neglect. There is also is confusion about what to report and who is responsible for making reports to appropriate law enforcement or oversight agencies. As a result, there is inconsistent reporting and follow-up action, which can only worsen an already serious issue.

In addition, abuse and neglect is reported together, confusing two distinct and separate issues. Neglect is much more commonly cited, while abuse is much rarer. The impact of this is potentially ineffective improvement and enforcement actions. Abuse is most often the result of an individual personnel issue, while neglect is often evidence of a system-wide clinical issue. Enforcement actions by CMS and required improvement actions by the center should address these distinctly. If these changes are not made, these ten recommendations are likely to be ineffective.

OIG Report—CMS Could Use Medicare Data To Identify Instances of Potential Abuse or Neglect: (1) compile a complete list of diagnosis codes that indicate potential physical or sexual abuse and neglect; (2) use the complete list of diagnosis codes to conduct periodic data extracts of all Medicare claims containing at least one of the codes indicating either potential abuse or neglect of adult and child Medicare beneficiaries; (3) inform States that the extracted Medicare claims data are available to help States ensure compliance with their mandatory reporting laws; and (4) assess the sufficiency of existing Federal requirements, such as conditions of participation and section 1150B of the Social Security Act, to report suspected abuse and neglect of Medicare beneficiaries, regardless of where services are provided, and strengthen those requirements or seek additional authorities as appropriate.

AHCA does not believe the first three recommendations made in the June 2019 OIG report entitled, *CMS Could Use Medicare Data To Identify Instances of Potential Abuse or Neglect* is an effective strategy to prevent and investigate abuse. The four recommendations in this report focus on additional data collection through claims data. There is a significant delay in accessing claims data, which would render the identification of these instances abuse and neglect largely meaningless for timely investigation and intervention, while at the same time creating additional burden for providers. Also, collecting and reviewing the hospital and nursing home medical record is only way to determine if the claims data is related to abuse or neglect. This is a labor-intensive activity that also takes more time. All of which takes surveyors away from inspecting nursing homes in a timelier manner and adds burden to providers to comping medical records for review. We believe the other recommendations and focusing on more timely visits and follow-up visits by the surveyors, along with better guidance on reporting potential abuse and neglect, will be a more effective use of resources. However, AHCA does support the fourth recommendation, as it relates to assessing the sufficiency and strengthening the requirements across all Medicare beneficiaries, regardless of services provided. AHCA believes it is imperative to standardize the requirements around abuse and neglect across all provider settings.

Question. Insofar as any of the recommendations proposed by the GAO or OIG could be better tailored, targeted, or otherwise enhanced to meet their desired goals without unduly increasing the administrative burden on facilities and/or diverting attention from patient and resident care, what steps should we and/or CMS take to ensure that we make the changes needed?

Answer. The recommendations made by the GAO and OIG will not be meaningful unless there is standardization in the definition of abuse and neglect across provider

settings, and the separation of abuse and neglect as it relates to enforcement actions, as stated above. In addition, the recommendations for additional tracking of data will not be effective due to the delay in processing these claims. This will only result in an increased paperwork burden and divert resources from residents.

Regarding the recommendations around standardized forms and additional reporting guidance, it will be important to limit the amount of information required to what is only most important. The amount of information conveyed should not detract from the facilities ability to assure the safety and well-being of the resident. The health care provider should focus on the safety and well-being of the resident, rather than collecting paperwork or information that the State or local law enforcement should be responsible for collecting.

QUESTIONS SUBMITTED BY HON. RON WYDEN

SECTION 1150B ENFORCEMENT

Question. One key provision of the Elder Justice Act established new elder abuse reporting requirements for nursing homes (section 1150B of the Social Security Act). The law required immediate reporting of any reasonable suspicion of a crime committed against a nursing home resident. Enforcement measures included civil monetary penalties of up to $300,000. HHS has never given CMS the authority to enforce this provision. Do you agree that CMS ought to be enforcing this Elder Justice Act 1150B requirement on reporting abuse?

Answer. While we support the intent of the Elder Justice Act to report abuse and neglect to the appropriate authorities, the reporting time frames and the confusion about what needs to be reported needs to be addressed. We support the intent to hold facilities accountable for reporting in a timely manner. We also support holding individual health-care workers and nonhealth-care workers accountable to reporting to their appropriate supervisor and manager in a facility, but do not support holding them accountable with large monetary penalties up to $300,000 as specified in the Elder Justice Act for the reasons spelled out below.

The examples used in the hearings and media and OIG/GAO reports all support rapid reporting of abuse and neglect. However, those examples do not represent the guidance provided by CMS on what must be reported or enforced through citations. The confusion on definitions and descriptions provided by CMS, as well as actual citations issued, reinforce reporting any instance of potential harm to authorities. As a result, in 2018 nursing homes reported over 200,000 cases to State agencies, of which only 20 percent were substantiated as representing any non-compliance with CMS regulations. Of the 20 percent that did result in a citation of non-compliance, most were NOT for abuse or neglect. Only 0.3 percent were cited for abuse or neglect and the majority of those were for instances not related to harm.

The GAO and OIG both found that local law enforcement and State Survey Agencies did not feel they got enough information to decide on how soon they needed to conduct their investigation. This is largely due to the 2-hour reporting requirement and the poor guidance on what cases need to be reported. Immediately or within the 2-hour window, facilities are also required to do the following (all of which we strongly support):

- Notify the physician and family member immediately upon discovering potential abuse.
- Take actions to ensure the safety and well-being of the resident, which would include conducting assessment of the resident and/or performing treatments as well as potentially arranging transportation to the emergency room.
- Remove the health care workers or employees who may be involved in the incident.

Thus, calling the State Survey Agency or local law enforcement within 2 hours with detailed information is often impossible and may even jeopardize the safety and well-being of the resident.

In addition, we have had numerous members receive complaints from the local law enforcement that they do not want many of the cases being called to them. Examples of the types of calls that local law enforcement does not want to receive could include:

- A bruise on a resident on a blood thinner may represent a potential allegation of abuse, but most of the time does not.
- A resident hit by another resident represents abuse per CMS guidelines and must be reported to local law enforcement.
- A person with dementia who does not remember where they are or where they place items, commonly will state that their personal belongs have been stolen by a person entering their room. That person often is an aide that, due to the resident's dementia, the resident doesn't remember and assumes is a stranger.

Currently, all of these examples must be reported to the authorities within two hours. Collecting the information to determine the circumstances around these examples can take more than 2 hours. As a result, to avoid being threatened with individual monetary penalties, the facility reports what information they have. The 2-hour reporting requirement applies to any time of day, including the middle of the night. CMS needs to provide better and clearer guidance on what incidents needs to be reported, otherwise the number of reported incidents will continue to increase.

Adding a monetary penalty to individuals not reporting within 2 hours will have two significant unintended effects and will not help prevent abuse or neglect from occurring. First, to avoid any chance of receiving a personal $300,000 financial penalty, individuals will report any incident or circumstance to assure they are not at any risk of such a penalty. Without explicitly clear guidance from CMS, this will result in a massive increase in reporting that will overwhelm the State Survey Agencies and local law enforcement. Also, every time a staff person reports to work and learns of the potential abuse or neglect, they will be required to notify the appropriate authorities, which will result in multiple reports for the same incident, often with very incomplete information. Second, as long as the definitions are different from hospitals and home health, and the penalty only applies to nursing homes, potential employees, including health-care workers such as nurses that are already in short supply, will seek employment elsewhere. Currently, CMS requires any fall with an injury of any nature (pain or bruising from a fall) to be reported consistent with the Elder Justice Act. However, a fall in the hospital with pain or bruising does not need to be reported. A majority of the incidents that must be reported in the nursing home setting do not need to be reported in hospitals or home health settings. In addition, any monetary penalty would require notification to their State professional licensure board and would also need to be noted on any future job applications to any healthcare setting. As such, healthcare workers, are not going to want to work in nursing homes.

Lastly, we are not aware of evidence that supports individual penalties as a method to prevent abuse or neglect. In fact, the Institute of Medicine (IOM) and other independent organizations examine patient safety do not recommend using penalties for failing to report or involved in medical errors or incidents as they have been shown to not prevent them and in fact may make the matter worse. Therefore, we do not support this approach as currently written in 1150B of the Elder Justice Act. The healthcare workers should be held accountable for reporting to their supervisor any suspicions, but not individually. Also, the language in 1150B of the Elder Justice Act should apply to all settings, not just nursing homes, to avoid creating a powerful disincentive for health-care workers to work in nursing homes.

In regard to the Elder Justice Act, we must ensure access to grants or other funding streams that can support recruitment, retention, and training initiatives in long-term care. In this context, long-term care should encompass all settings and providers, rather than being limited to long-term care facilities. We recommend support for any initiatives that can ease burden of accessing and applying for grant monies including quick turnaround for review of grants and awarding of the funding.

SCOPE OF THE SPECIAL FOCUS FACILITIES PROGRAM

Question. CMS recently released the list of 435 nursing homes that are candidates for the Special Focus Facilities Program (SFF). As you know, once on the SFF list, these nursing homes are subject to additional inspections and oversight. However, the number of homes placed in this program is arbitrarily limited by CMS to a maximum of 88 facilities (one-half of 1 percent of all nursing homes). The number of candidates is itself also arbitrarily limited by CMS. It is likely that there are additional nursing homes that have substandard performance on par with the SFF candidates, but which do not themselves become candidates because of the CMS restriction on the number of candidate slots. How many nursing homes in this country do

you believe would actually qualify for the "poorly performing" criteria outlined in the SFF program and need additional attention to ensure residents are being cared for properly? Should the SFF program be expanded to encompass all poorly performing nursing homes? If not, what measures would you recommend to address the deficiencies in their performance?

Answer. The current SFF list is based on a facility ranking within their State on their survey score. The State agency reviews a list of the worst-ranked facilities in their State to select the 2–3 to be on the SFF list. Using the survey score as the sole data to identify "poorly performing" is not effective. Looking at the SFF candidate list that Senators Casey and Toomey released demonstrates this problem as the survey score, which is based on points assigned to each survey citations received over the past 3 to 4 years, varies tremendously between States. The variation in the number of citations is over four-fold between the nine CMS regions from a low of 3.6 in Region II to 14.5 in Region X per CMS's QCore website. The survey scores to get on the SFF list in each State varied from a low of 34 in NH to a high of 445 in KY (see Table 4 for the minimum survey scores for being added to the SFF candidate facilities in each State rank ordered from lowest to highest).

In some States and regions, a single incident of poor quality will result in multiple citations while in others, it may only result in a single citation. For example, a fall with a fracture may be cited as a deficient practice related to non-compliance with regulations to prevent accidents, and the same type of incident in another State results in not only a citation for accidents but citations related to care planning, quality assurance, administrator leadership, and neglect. This will result in a much worse survey score for the facility with multiple citations. Yet the facility with a single citation may have low staffing and a very high rate of falls with injury based on the CMS outcome measures, while the facility with multiple citations may have high staffing levels and very low rate of falls with injury on the CMS outcome measures. When you examine the SFF candidate list of facilities, you can find some with high staffing levels and good outcome measures, others with average staffing and average outcomes and yet others with poor staffing and outcomes. If the purpose of the SFF is to identify poor performing facilities, we would recommend using additional data beyond just the survey inspections to more accurately identify facilities that may fall on the SFF.

Table 4. State Rank Ordered by Minimum Survey Score to Get on SFF Candidate List

STATE	# SNFs	# SFF in State	# SFF Candidate Facilities in State	Min Survey Score to SFF Candidate
NH	73	1	4	34
NJ	360	2	9	41
FL	689	2	14	56
NY	613	2	15	68
ND	79	1	5	70
RI	83	1	4	76
ME	98	1	4	77
VT	36	1	5	81
WY	35	1	5	86
AZ	145	1	4	92
NV	61	1	4	112
PA	687	4	16	131
OH	963	5	18	140

Table 4. State Rank Ordered by Minimum Survey Score to Get on SFF Candidate List—
Continued

STATE	# SNFs	# SFF in State	# SFF Candidate Facilities in State	Min Survey Score to SFF Candidate
CT	223	1	3	141
IN	546	3	14	144
LA	276	1	4	151
HI	44	1	5	152
MS	198	1	5	155
IA	431	2	9	159
DE	44	1	5	161
AL	227	1	4	166
MO	514	3	11	169
OK	295	2	10	176
MD	225	1	4	181
MN	373	2	9	193
GA	357	1	8	195
MT	71	1	5	195
NC	424	2	7	196
UT	100	1	3	200
SD	103	1	4	202
IL	724	4	14	204
CO	226	1	4	217
SC	184	1	5	218
WI	371	2	8	238
VA	281	1	4	240
MI	440	1	9	243
CA	1176	6	27	248
NE	209	1	5	255
TN	311	2	6	273
MA	392	2	9	274
KS	326	2	9	284
ID	80	1	4	286
AR	224	1	5	290
WV	119	1	5	312

Table 4. State Rank Ordered by Minimum Survey Score to Get on SFF Candidate List—Continued

STATE	# SNFs	# SFF in State	# SFF Candidate Facilities in State	Min Survey Score to SFF Candidate
NM	73	1	5	332
TX	1,209	5	26	350
OR	134	1	4	366
WA	210	1	5	407
KY	282	1	5	445

Also, if the purpose of designating SFFs are to get the poor performing facilities to improve, the current program is not effective. A SFF designation only results in greater number of inspections and more penalties. This assumes that greater scrutiny, more citations and more penalties to a facility that over the past 3 years has already received a higher number of citations, fines and other penalties, will change outcomes. The SFF list is the same size for all States, which is fundamentally skewed. The staffing and quality vary between States and the number of facilities in States also vary. Using a fixed proportion or number of facilities in each State will result in some good facilities on the SFF list in some States and poor performing facilities in other States that may warrant a SFF designation being left off.

One of the strongest predictors of staffing levels and quality relates to Medicaid reimbursement levels in the State. Any efforts to address poor performing facilities needs to examine Medicaid reimbursement policies and the size of a facilities Medicaid census, as Dr. Grabowski testified during the March 2019 Senate Finance Committee hearing on abuse and neglect.

TRANSPARENCY AND TREATMENT OF POORLY PERFORMING NURSING HOMES IN NURSING HOME COMPARE

Question. The 88 facilities that are "in" the SFF program have their "star" ratings removed from Nursing Home Compare as a warning to consumers. Although CMS has now adopted a policy of disclosing the list of candidates, nursing homes that are classified as candidates for the program, *i.e.,* they are equally bad but not enrolled, are allowed to retain their "star" ratings. Consequently, consumers using Nursing Home Compare are *not* clearly warned about them. Would you agree that SFF candidates should treated in the same way on Nursing Home Compare as the 88 facilities in the program or in some other way be disclosed on the site? If not, how should they be disclosed?

Answer. AHCA disagrees with removing the star rating. The star rating combines three very distinct quality information, each of which provides valuable information to the consumers. Removing the star rating and information from the website decreases transparency and restricts information available to consumers. While information on the number and types of abuse and neglect citations is currently available on Nursing Home Compare, with only one or two clicks from the facilities report page. As shown with Figures 4–6 below (screen shots from NHC using an Iowa facility), if a website user clicks on "view all health inspection details," a report listing the number of different citations including abuse and neglect appear. As a website user scrolls down the page, the names of each deficiency along with the scope and severity are also provided, as shown in Figures 4–6 below. A website user can also view a copy of the actual report that lists all the findings. The SFF list is also based only on the survey inspection findings. As described in the previous answer, the survey findings vary tremendously between States and even within regions within large States. For example, in some States the minimum score to be on the SFF candidate list ranges from 34 to 455 (see Table 4 above). This is an enormous difference. Also, in some States, facilities on the SFF have a very reasonable survey score, while in other States, facilities with numerous deficiencies are not on the list at all. Also, there are facilities with excellent survey inspections (4- or 5-star ratings on the survey component only) but who have very low staffing levels and very poor quality outcomes. The SFF list should be based on information across all three components. Suppressing information for those on the SFF list only re-

stricts information that consumers can access to decide. We do support having a special designation warning consumer of struggling facilities, but it should be based on reliable information and information that covers different domains of quality.

Figure 4. Screen Shots from Nursing Home Compare Website

bb

Print all information

Nursing home profile

Back to Results

General information | Health inspections | Fire safety inspections | Staffing | Quality of resident care | Penalties

ACCORDIUS HEALTH AT ST MARY, LLC

Overall rating: ★●●●●
Much Below Average

Health inspections

This page of Nursing Home Compare reports information about a nursing home's health inspections, complaints files and any resulting citations. Nursing homes that are certified by Medicare and Medicaid are inspected each year. Health care professionals inspect each nursing home and look for any health and safety citations. Learn more.

The health inspection star rating is based on each active provider's current health inspection survey and the 2 prior surveys, as well as findings from the most recent 3 years of complaints information and inspection revisits.

	ACCORDIUS HEALTH AT ST MARY, LLC
Health Inspection rating	★●●●● Much Below Average
Date of most recent health inspection	08/16/2018 View full report
Total number of health citations	9
Average number of health citations in Iowa	5.4
Average number of health citations in the U.S.	8.0
Date(s) of complaint inspection(s) between 7/1/2018 - 6/30/2019	08/16/2018 View full report
Number of complaints in the past 3 years that resulted in a citation	16
Number of times in the past 3 years a facility-reported issue resulted in a citation	0
View all health inspection details	View all health inspection, complaint, and facility-reported issue details

Figure 5. Screen Shots from Nursing Home Compare Website

Medicare.gov | Nursing Home Compare

The Official U.S. Government Site for Medicare

Health Inspection Summary

ACCORDIUS HEALTH AT ST MARY, LLC
800 EAST RUSHOLME STREET
DAVENPORT, IA 52803
(563) 322-1668

Deficiency Category	Inspection Date: 08/16/2018 Complaint Reporting Period: 7/1/2018 - 6/30/2019	Inspection Date: 06/08/2017 Complaint Reporting Period: 7/1/2017 - 6/30/2018	Inspection Date: 05/19/2016 Complaint Reporting Period: 7/1/2016 - 6/30/2017
Freedom from Abuse, Neglect, and Exploitation Deficiencies	0	1	0
Quality of Life and Care Deficiencies	2	1	7
Resident Assessment and Care Planning Deficiencies	2	0	1
Nursing and Physician Services Deficiencies	2	1	1
Resident Rights Deficiencies	1	1	2
Nutrition and Dietary Deficiencies	1	2	2
Pharmacy Service Deficiencies	0	0	1
Environmental Deficiencies	1	3	0
Administration Deficiencies	0	0	0

Detailed Result for Inspection on 08/16/2018

Date of last standard health inspection:	08/16/2018	View Full Report - Opens in a new window
Date(s) of complaint inspection(s) between 7/1/2018 - 6/30/2019:	08/16/2018	View Full Report
Total number of Health Deficiencies for this nursing home:	9	
Average number of Health Deficiencies in Iowa:	5.4	
Average number of Health Deficiencies in the United States:	8.0	

Freedom from Abuse, Neglect, and Exploitation Deficiencies

No Freedom from Abuse, Neglect, and Exploitation Deficiencies were found during this inspection period.

Figure 6. Screen Shots from Nursing Home Compare Website

Freedom from Abuse, Neglect, and Exploitation Deficiencies

Inspectors determined that the nursing home failed to:	Inspection Date	Date of Correction	Level of Harm (Least to most)	Residents Affected (Few, Some, Many)
Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.	11/09/2017	11/21/2017	1 **2** 3 4 2 = Minimal harm or potential for actual harm	Few

Quality of Life and Care Deficiencies

Inspectors determined that the nursing home failed to:	Inspection Date	Date of Correction	Level of Harm (Least to most)	Residents Affected (Few, Some, Many)
Make sure services provided by the nursing facility meet professional standards of quality.	06/08/2017	06/30/2017	1 **2** 3 4 2 = Minimal harm or potential for actual harm	Few

Resident Assessment and Care Planning Deficiencies

No Resident Assessment and Care Planning Deficiencies were found during this inspection period.

ACCESS AND REIMBURSEMENT

Question. Medicaid is the primary payer of long-term care in the United States helping to cover the cost of care for two out of three individuals in nursing homes. Due to State fiscal pressures, reimbursement rates under State Medicaid programs for nursing facility care can oftentimes be insufficient, not consistently covering the cost of high-quality care for high needs residents. Instead of looking for ways to strengthen the program to ensure the millions of seniors who rely on Medicaid for nursing and home-based services have access to the care they need and that the providers they depend on can deliver the high-quality care they deserve, Republicans and the Trump administration would rather slash over a trillion dollars from the program through block grants and caps. In addition to fighting back against these efforts, I have written a number of times to this administration and the previous administration about the need for appropriate oversight and enforcement of Medicaid's equal access standards and the need to ensure sufficient provider payment rates. However, we have time and time again seen this administration undermine access to essential care, most recently through a proposal to repeal the 2016 Medicaid Access rule, which among other things, would have required States to review the impact on access to care before slashing provider payment rates and payments to nursing facilities. What impact would legislative and administrative proposals like these have on providers and their ability to provide high-quality care to the rapidly growing population of older Americans that will need long-term care?

Answer. It is important to ensure that Medicaid payment rates are sufficient to allow for providing high quality of care, particularly since Medicaid is the primary payer of long-term services and supports. As compared to other payers, Medicaid is an underpayer, reimbursing providers approximately at $0.89 per dollar used in providing care. These combined effects make it very difficult for providers to invest in infrastructure and systems necessary to provide high quality care. In many cases, the inadequate reimbursement rate can reduce access to long term care, because it is the business model is unsustainable. As a result, we witness many closures of nursing homes, with the majority of those concentrated in rural locations, where patients have few, if any, other alternatives to obtaining long term care. When these closures occur, they lead to interruptions in care and displacements of all patients, thus negatively impacting all, regardless of payer source.

Academics have examined the link of Medicaid reimbursement to quality and many studies conducted in the past two decades (see Table 5 "Medicaid Payment Policies") have found that increasing Medicaid payment rates increased quality of care, or decreased incidence of negative outcomes such as pressure ulcers, hospitalizations, ADL decline, and mortality.

Further, many peer-reviewed studies in the past 20 years have looked at the relationship between Medicaid census in nursing homes and the quality of care (see table below, section "Medicaid Census"). Three studies (that looked at hospitalizations) found that increased Medicaid census or number of Medicaid reimbursed days were associated with increased likelihood of hospitalization, and one article (that looked at risk-adjusted ulcers) found that the positive relationship between Medicaid payment rates and quality was stronger in nursing homes with a high proportion of Medicaid residents. As the U.S. older population is expected to double by 2040 potentially increasing the population of Medicaid beneficiaries needing long term care services, providers will find it increasingly difficult to provide high quality of care, if they can even remain open. Thus, this highlights the need for Medicaid to provide sufficient reimbursement rates.

Table 5: Academic Published Studies on Medicaid Relationship to Quality

Publication	Medicaid Feature	Results		
		Better Outcomes	Worse Outcomes	No Effect
Medicaid Payment Policies				
Bowblis et al., 2017	Anticipated and Actual Changes in Medicaid Reimbursement Rates			Moderate-Severe Pain, ADL Decline, Bowel/ Bladder Incontinence, UTI, Pressure Ulcers, Falls with Major Injury
Foster et al., 2015	Pass-Through Subsidies	Decreases Incidence of Pressure Ulcer Worsening by 0.9%		ADL Decline, Persistent Pain Rates
Grabowski, 2001	$1 Increase in Reimbursement	0.9969 to 0.9983 Lower Likelihood of Pressure Ulcers		
Grabowski, 2002	Case-Mix Reimbursement			Pressure Ulcers
Grabowski, 2004	$1 Increase in Reimbursement	0.015 Percentage Point Decrease in Pressure Ulcers		
Grabowski et al., 2004a	10% Increase in Reimbursement	1% Decrease in Pressure Ulcers		
Grabowski et al., 2004b	Reimbursement Rates	Facilities in highest payment quartile had significantly lower rates of pressure ulcers than those in the lower quartile (14.8% to 16.1%)	Facilities in highest payment quartile had significantly higher rates of pain than those in the lower quartile (13.4% to 11.1%)	
Gruneir et al., 2007	$10 Increase in Reimbursement	0.95 Lower Odds of Hospitalization		
Intrator et al., 2004	$10 Increase in Reimbursement	9% Reduction in Risk of Hospitalization and 12% Decrease in Mortality		

Table 5: Academic Published Studies on Medicaid Relationship to Quality—Continued

Publication	Medicaid Feature	Results		
		Better Outcomes	Worse Outcomes	No Effect
Intrator et al., 2007	$10 Increase in Reimbursement	5% Lower Odds of Hospitalization		
Mor et al., 2011	$10 Increase in Reimbursement	Increased Likelihood of Meeting Nursing Home Quality Thresholds by 2% for Pressure Ulcers, 5% for Pain Control, and 9% for ADL Decline		
Werner et al., 2013	Pay-for-Performance	Decreased Moderate-Severe Pain by 0.5% and Pressure Ulcers by 0.3%		Falls, Weight Loss
Medicaid Census				
Cai et al., 2011	Medicaid Census		Increased Hospitalizations in For-Profit Facilities	
Carter, 2003	Medicaid Census		Increased Hospitalizations	
Carter et al., 2003	Medicaid Census		10% Higher Odds of Hospitalization	
Grabowski et al., 2004a	Medicaid Census		Relationship Between Pressure Ulcers and Payment Especially Strong in High-Medicaid Nursing Homes	
Kang-Yi et al., 2011	Medicaid Census			Psychosocial Well-Being Outcomes
Shippee et al., 2015	Medicaid Census		Increased Odds of Lower Quality of Life Scores for Personal Attention (0.76), Engagement (1.07), and Summary Score (2.38)	Environment, Food, Negative Mood, Positive Mood

QUESTIONS SUBMITTED BY HON. SHELDON WHITEHOUSE

Question. Entering a nursing home can be a traumatic time for the patient and his or her family. Often buried deep in the patient admittance contracts are clauses that force patients into secret legal proceedings if the nursing home negligently or even intentionally injures or abuses the patient. Not only does this rob the patient of his or her constitutional right to a day in court, but it also keeps knowledge of the abuse secret from other potential victims.

A 2015 Federal Government study found that less than 7 percent of people who'd signed arbitration agreements as part of credit card contracts understood that it meant they gave up their right to sue the company in the future.

Do you think that nursing home patients, who are already enduring a stressful and emotional situation, are in a position to fully understand what they are signing away?

Answer. Arbitration enables parties to settle disputes fairly and with lower cost, and with results that are very similar to outcomes in court. Moreover, courts ensure that arbitration procedures are fair to all sides, and routinely invalidate arbitration agreements that fail to meet that requirement. This time-tested approach is beneficial to all parties. AHCA believes arbitration agreements are an essential legal remedy beneficial to both residents and SNFs. Court actions often take years before they go to trial and reach final resolution. Arbitration disputes on average settle a bit faster and result in similar awards. A 2018 study by Aon found that a greater percentage of arbitration claims produced payments over $25,000 than claims in court (60.6 percent vs. 55.2 percent).

Issues that require legal or dispute resolution are rare. Of the 3.4 million people treated in SNFs each year, significantly less than one percent have issues that are serious enough to require formal dispute resolution. The vast majority of these cases reach a settlement before going to court or entering arbitration.

SNFs are not the only health-care providers that use arbitration. For example, arbitration is used as a dispute resolution system by the Kaiser health system, and 94 percent of the parties and lawyers who participated in 2017 said the arbitration system was better or the same as the judicial process.

Question. If a nursing home is abusing or neglecting patients, funneling any lawsuits into secretive private legal proceedings allows the nursing home to conceal a pattern of abuse. Correct?

Don't other current and prospective patients have a right to know if a nursing home is mistreating its patients?

Answer. Skilled nursing facilities are subject to unannounced rigorous and frequent government inspection. recertification inspections at least every 15 months. Additional complaint surveys are conducted as needed. SNFs are required to report suspected abuse and neglect to CMS, which in turn is charged with prioritizing investigations.

Survey results are made public. Facilities must post survey findings. Additionally, CMS's Nursing Home Compare website posts survey reports and plans of correction. These survey findings are part of a facility's star rating.

In addition, arbitration agreements do not prevent parties from discussing their claims or an arbitrator's decision with government regulators or law enforcement agencies, or from discussing their claims or the arbitrator's decision in public. Provisions in arbitration agreements that purport to impose such restrictions are invalidated by courts.

PREPARED STATEMENT OF LORI SMETANKA, EXECUTIVE DIRECTOR, NATIONAL CONSUMER VOICE FOR QUALITY LONG-TERM CARE

Chairman Grassley, Ranking Member Wyden, and distinguished members of the committee, thank you for holding this important hearing. My name is Lori Smetanka, and I am the executive director of the National Consumer Voice for Quality Long-Term Care, a national advocacy organization representing individuals living in long-term care facilities and their families. I am testifying today on behalf of my own organization, the membership of which includes State and local advocacy organizations, ombudsmen, residents of nursing homes and their families; and also on

behalf of partner advocacy organizations, the Long Term Care Community Coalition, and California Advocates for Nursing Home Reform.

Under Federal law, every nursing home must provide residents with services that help attain and maintain their highest practicable physical, mental, and psychosocial well-being. However, with great dismay, reports continue to indicate that too many nursing homes fail to meet minimum standards of care that they voluntarily agreed to follow as a requirement of participating in the Medicare and Medicaid programs. Reports, such as the ones identified by the Office of the Inspector General and the Government Accountability Office in the first panel show us that all nursing home residents need greater protections to ensure their quality of care and quality of life.

Sadly, the failure to protect and expand residents' rights and protections means that the stories of Patricia Blank and Maya Fischer, who were the victims of abuse and neglect, are not unique. My colleagues and I communicate daily with residents, family members, citizen advocates, and long-term care ombudsmen who see and experience the failures of the systems designed to protect residents.

We need greater accountability for the billions of public dollars that annually go to nursing facilities and which are intended to provide care and services for some of our country's most vulnerable individuals.

We can do better, and today I offer recommendations in the following areas.

REQUIRE STANDARDS FOR A SUFFICIENT, WELL-TRAINED, WELL-SUPERVISED WORKFORCE

A primary factor for ensuring that residents receive good care, and that will go a long way in the prevention of abuse and neglect, is to ensure that nursing homes have adequate numbers of competent staff. Studies have established the relationship between staffing levels and quality of care. When there is not enough well-trained and well-supervised staff, residents suffer. They experience painful pressure ulcers, malnutrition, dehydration, infections, preventable hospitalization, injuries, and more. Severe lack of staff, when combined with stress and burnout, are factors that can lead to neglect and abuse.[1]

Federal law requires nursing facilities to have a registered nurse on duty 8 consecutive hours every day, licensed nurses 24 hours a day, and sufficient nursing staff.[2] "Sufficient staff," however, is vague and ambiguous. Without a specific definition of "sufficient," in terms of actual numbers of staff, the facility itself decides what is sufficient, without having to demonstrate any reason for that determination. Studies[3,4] show that 4.1 hours per resident day of care is the minimum staffing ratio necessary to prevent common quality problems. Yet most facilities do not meet that standard.

The payroll-based staffing data which CMS collects, show that staffing levels are lower than previously self-reported by nursing facilities,[5] and an analysis of this data recently reported in *Health Affairs,* shows that "the majority of days, nursing home staffing levels are below what the CMS expects."[6] The findings further indicated that nursing homes fail to properly staff registered nurses, as well as fail to maintain staffing levels on evenings and weekends. Additionally, the data showed what residents and families have been telling us for years, that staffing levels increased only in anticipation of the annual surveys.[7]

The 2016 Final Rule on Requirements of Participation for Long-Term Care Facilities, included provisions that took positive steps toward improving staffing. The 2016 Final Rule (1) required staff to have "appropriate competencies and skill sets" to care for the residents living in the facility; (2) required training around issues

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[1] Catherine Hawes, Ph.D., "Elder Abuse in Residential Long-Term Care Settings: What Is Known and What Information Is Needed?", National Academy of Sciences 2003.

[2] 42 U.S.C. 1395i–3; 42 U.S.C. 1396r.

[3] Abt Associates for CMS, "Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes," December 2001.

[4] Edelman, T., "Nurse Staffing Deficiencies in Nursing Facilities: Rarely Cited, Seldom Sanctioned," CMA Report, January 10, 2019.

[5] Jordan Rau, "'Like a Ghost Town': Erratic Nursing Home Staffing Revealed Through New Records," *Kaiser Health News,* July 13, 2018.

[6] Fangli Geng, David G. Stevenson, and David C. Grabowski, "Daily Nursing Home Staffing Levels Highly Variable, Often Below CMS Expectations," *Health Affairs* 38, N. 7 (2019): 195–1100.

[7] *Id.*

such as abuse prevention and dementia care; and (3) required an annual Facility Assessment which mandated nursing homes to assess necessary staffing needs for their facility by taking into consideration the number, acuity, and diagnoses of its resident population.[8] Here, for the first time, would be a way to require providers to think about what would be "sufficient" and to have documentation and reasons that regulators could use to hold facilities accountable. Last week, however, in its effort to "reduce the burden on providers,"[9] CMS issued a proposed rule to reduce the frequency of the facility assessment to every 2 years.[10] Reducing the frequency of this assessment is dangerous.

We recommend that Congress establish and enforce minimum requirements for sufficient numbers of direct care nursing staff, including that a registered nurse be on-site 24 hours per day.

We are aware of the arguments providers present as reasons for not hiring more staff. They have been making these arguments for decades—that the pool of workers is shrinking, and they do not have the funds to hire. However, there are other reasons that we have not made more progress in improving staffing levels and nursing home quality. While trying to control costs, Medicare does not conduct financial audits and has no limit on administrative costs and profits. Consequently, the Medicare Payment Advisory Commission (MedPAC) reports that Medicare margins have exceeded 10 percent for 18 consecutive years.[11] Under current Federal and State payment systems, nursing homes are able to make choices on how to allocate their resources with few regulatory restrictions. In 2010, for example, California nursing homes spent only 36 percent of total revenues (including Medicare and Medicaid) on staffing and over 20 percent on administration and profits.[12] Ultimately, without more information about where the public's reimbursement dollars are going, we should not let providers off the hook.

ESTABLISH STANDARDS AND OVERSIGHT FOR FACILITY OWNERSHIP AND OPERATION, AND EXPAND ACCOUNTABILITY TO THE CORPORATE LEVEL

There have been significant changes in the ownership and management of nursing homes, with an increasing number of nursing facilities part of a multi-facility or corporate structure, and an increase in private equity ownership. Division of ownership and management is occurring among numerous affiliated entities that derive profits, but who are not responsible for the quality of care. Further, many of the decisions that affect care, including operational budgets and staffing levels, are made at the corporate level, yet CMS oversight is limited to individual facilities.

Currently no meaningful Federal criteria exist for determining who is eligible to receive Medicare and Medicaid certification, with CMS largely relying on State licensure processes. In many States, there is no evaluation of an entity's financial or management capacity to successfully operate these facilities and provide quality care.

The collapse of Skyline Healthcare in spring 2018 whereby the company became financially insolvent and essentially abandoned nursing homes it owned or managed across eight States, left States to step in and assume facility operations through receivership in order to make sure the residents received food and care. Thousands of residents and facility staff have been affected, suffering through poor living and working conditions, facing loss of home and jobs as many of the facilities are closing, some in communities where alternative options are limited or nonexistent. We are hearing of residents being moved hundreds of miles from their families and friends, some even to different States.

We recommend that (1) CMS be given explicit statutory authority to hold corporations accountable when patterns of poor care are identified across their facilities; (2) Congress hold hearings on these changing patterns of ownership and management and the implications for effective Federal oversight; (3) Minimum criteria be established as a condition of Medicare and Medicaid certification for assuming ownership

[8] 42 CFR § 483.70(e).

[9] 84 Fed. Reg., 34737 (July 18, 2019). The 32-page document in the Federal Register uses the word "burden" or "burdensome" 102 times, describing burdens on facilities.

[10] 84 Fed. Reg. 34737, 34745 (July 18, 2019).

[11] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy,* p. 193 (March 2019), *http://medpac.gov/docs/default-source/reports/mar19_medpac_entire report_sec_rev.pdf?sfvrsn=0.*

[12] Harrington, Charlene, John F. Schnelle, Margaret McGregor, and Sandra F. Simmons, "The Need for Higher Minimum Staffing Standards in U.S. Nursing Homes," *Health Services Insights,* 2016; 9:13–19.

or management of a nursing home, including criteria for denying or revoking certification; and (4) Federal law explicitly require that owners/operators that fail to comply with nursing home closure requirements be excluded from participation in Medicare and Medicaid for a specified period of years.

We further recommend that Congress (1) improve financial accountability through auditing of Medicare cost reports; (2) require transparency through detailed financial reporting of related-party companies and owners; and (3) enact a medical loss ratio that limits administrative costs and profits.

IMPLEMENT, ENFORCE, AND PREVENT THE ROLLBACK OF STANDARDS

Nearly 3 decades after passage of the Nursing Home Reform Act and implementation of corresponding regulations, there continues to be inadequate and uneven oversight and enforcement of standards. Maintaining a strong oversight and enforcement system is a key factor in preventing and addressing abuse and neglect in nursing facilities.

State Survey and Certification Agencies, responsible for conducting annual surveys, complaint investigations, and monitoring compliance, are under-staffed and under-funded. The lack of resources appears to hamper their ability do more timely complaint investigations and hire enough staff to carry out the necessary oversight and follow up.

Examples of inadequate nursing home oversight include low complaint substantiation rates[13, 14] and findings of harm in less than 5 percent of deficiency citations.[15] Enforcement has been further weakened by policy changes that CMS has implemented. One of the most significant examples is making per instance CMPs the recommended remedy rather than per day fines in all but a few limited circumstances. The result is generally lower penalties imposed for noncompliance. This change is counterproductive. The threat of fines, high enough to be more than the "cost of doing business," is a critical deterrent to abuse and substandard care, particularly when they are large enough to impact a facility's actions. Yet policy revisions are already having an effect: the average fine is now $28,405 compared to $41,260 in 2016.[16]

Further, the recent report on Special Focus Facilities released by committee members, Senators Casey and Toomey,[17] has drawn important attention to those nursing facilities with persistent care problems. Release of the list of candidates for the Special Focus Facility program is important for consumers seeking information about long-term care facilities, and CMS has agreed to release the candidate list moving forward.[18] The list needs to be posted in a location, such as Nursing Home Compare, that is regularly visited by and easily accessible to consumers, and candidates should be designated with an icon on Nursing Home Compare. The Special Focus Facility program, however, has failed to live up to expectations that with intense monitoring and enforcement, the poorest performers would achieve and remain in compliance. Many facilities never "graduate" from the program, or they quickly fall back into non-compliance when they leave the program.[19]

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[13] One-third of immediate jeopardy and high priority complaints are substantiated by State survey agencies. Office of Inspector General, "A Few States Fell Short in Timely Investigation of the Most Serious Nursing Home Complaints: 2011–2015," HHS OIG Data Brief, September 2017, OEI–01–16–00330.

[14] GAO, *Federal Monitoring Surveys Demonstrate Continued Understatement of Serious Care Problems and CMS Oversight Weaknesses,* GAO–08–517 (May 9, 2008); GAO, *Addressing the Factors Underlying Understatement of Serious Care Problems Requires Sustained CMS and State Commitment,* GAO–10–70 (November 24, 2009); GAO, *Some Improvements Seen in Understatement of Serious Deficiencies, but Implications for the Longer-Term Trend Are Unclear,* GAO–10–434R (April 10, 2010).

[15] CMS, *Nursing Home Data Compendium 2015 Edition,* Figure 2.2.e. Percentage Distribution of Scope and Severity of Health Deficiencies: United States, 2014, p. 48 *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Downloads/nursinghomedatacompendium_508-2015.pdf.*

[16] Jordan Rau, "Trump Administration Cuts the Size of Fines for Health Violations in Nursing Homes," *Kaiser Health News,* March 15, 2019.

[17] U.S. Senator Bob Casey, U.S. Senator Pat Toomey, "Families' and Residents' Right to Know: Uncovering Poor Care in America's Nursing Homes," June 2019.

[18] *https://www.cms.gov/newsroom/press-releases/cms-statement-quality-care-americas-nursing-home-facilities.*

[19] "Special Report—'Graduates' From the Special Focus Facility Program Provide Poor Care" (CMA Alert, June 20, 2019), *https://www.medicareadvocacy.org/graduates-from-the-special-focus-facility-program-provided-poor-care/.*

Preventing persistent care problems and yo-yo compliance is a primary goal of the Federal enforcement system. Increased efforts to implement the enforcement system are necessary, particularly related to accurately citing deficiencies and imposing appropriate penalties for noncompliance.

Strong, resident focused regulatory standards are critical to addressing and preventing poor care. The issuance last week by CMS of final rules allowing pre-dispute arbitration and proposing rollbacks to the revised nursing home rules published in 2016 are steps in the wrong direction. These new rules provide less protections for residents and less accountability for nursing facilities by, among other things, weakening standards relating to infection prevention, use of antipsychotic medications, and responding to resident and family grievances.[20]

We recommend that Congress take immediate action to improve the Federal oversight and enforcement system, including (1) appropriating and allocating additional funding for the Survey and Certification system; (2) incorporating into statute important provisions from the 2016 nursing facility regulation, such as a requirement for an annual facility assessment; a ban on pre-dispute arbitration; time frames for reporting abuse or neglect to the State survey agency; and grievance protections; (3) expanding and strengthening the Special Focus Facility program by specifying graduation rules for SFFs, requiring CMS to identify SFF candidates each month on Nursing Home Compare, and requiring that CMS impose only per day, not per instance, CMPs for SFFs.

We additionally recommend that Congress enact legislation, similar to the bipartisan Improving Dementia Care Treatment in Older Adults Act proposed by Senator Grassley in 2012 in response to the OIG's findings of widespread off-label use of antipsychotic drugs in nursing homes; if enacted, the bill would have required residents and their designated agents to be informed of the possible risks and side effects of antipsychotics, as well as alternative treatments. Today, most residents and families are still unaware of the serious medical and social side effects and risk of death from psychotropic drugs, which have FDA Black Box warnings against use to treat elderly persons with dementia and were named in a Senate report more than 40 years ago as chemical restraints. Legislation should require facilities to secure informed consent that includes an explanation of the use of the drug; medical reason for which it is prescribed; non-pharmacologic alternatives; side effects and risks; whether the drug is prescribed for off-label purposes; proposed duration, dose and frequency, and potential interactions with other drugs.

INCREASE TRANSPARENCY OF INFORMATION

Choosing a long-term care facility is a decision that residents and families often make quickly and in a time of stress, such as when a family member is hospitalized but unable to go directly home. The rushed nature of the decision makes it especially important for the information on the Federal website Nursing Home Compare to be reliable, accessible, as comprehensive as possible, and easily understandable. Families can return to Nursing Home Compare after their relative's admission to help them in monitoring and overseeing care. CMS has made gradual, important improvements in the information presented on Nursing Home Compare and used to determine a facility's star rating. An important example is the addition of staffing information from auditable data in the Payroll-Based Journal. Additional steps can be taken to improve the reliability and usefulness of Nursing Home Compare and the Five Star Rating System.

We recommend that Congress direct CMS to: (1) Enhance the data used to determine the staffing star rating by including elements such as turnover of staff, and usage of agency staff; (2) eliminate the inclusion of self-reported Quality Measures in the star rating calculations; (3) Add an icon designating facilities with deficiencies for abuse deficiencies; and (4) Add an icon showing facilities that have a generator in case of natural disaster or emergency.

STRENGTHEN AND FUND ELDER JUSTICE PROVISIONS

Reauthorization and full implementation of the Elder Justice Act is an important and impactful step that Congress can take to address the abuse of elders in this country. Numerous GAO and OIG reports, including those highlighted today at this hearing, show the need for continued Federal and State action to strengthen elder abuse reporting, prevention, and response. The failure of appropriate reporting of abuse or suspicions of abuse is unacceptable. Failures to report prolong the victim-

[20] 84 Fed. Reg. 34787–34768 (July 18, 2019).

ization and suffering of those being abused and put at significant risk other residents who are in contact with the abuser.

We recommend that Congress take the following actions: (1) add State surveyors to the list of covered individuals who are required to report suspicion of abuse or neglect to law enforcement; (2) direct CMS to fully enforce the Affordable Care Act's requirement for individuals to report possible criminal acts to law enforcement; (3) impose civil money penalties against the nursing home or other licensed entity for failure to report abuse or suspicions of a crime; and (4) increase funding for the Long-Term Care Ombudsman Program to enhance the program's capacity to assist in abuse prevention and advocate for residents who have been victimized.

Additionally, better screening of individuals seeking to work in a long-term care facility through a Federal background check system is necessary to screen out those individuals with criminal records that pose a danger to residents' person or property. The National Background Check Program (NBCP), which was established as a voluntary program to help States implement and improve employee background check systems, and has, to date, screened out nearly 80,000 individuals[21] with a history of patient abuse or a violent criminal background has the framework that can be built upon if States were required to implement its provisions.

We recommend that Congress amend the National Background Check Program and direct CMS to provide funding to the remaining States that have not drawn down funds and implemented the system. All States, those newly receiving funding and those that have received funding but did not fully implement the program's requirements, must be held accountable for fulfilling the requirements in the Act. In addition, by 2022, Congress should require background checks to be done by all SNFs/NFs certified by Medicare and Medicaid as a Requirement of Participation.

CONCLUSION

As previously mentioned, just last week, CMS took steps to further weaken the oversight system and residents' rights with the publication of new final rules allowing pre-dispute arbitration[22] and proposing[23] rollbacks to the revised nursing home rules published in 2016.[24]

The 2016 revised Federal nursing home regulations, developed over a 4-year process of listening to consumers, nursing home providers, health-care experts, and the public through formal notice and comment,[25] included important new protections for vulnerable individuals and requirements to reduce the likelihood of resident harm, such as robust requirements for staff training and prevention; reporting and responding to abuse, neglect and exploitation; banning forced arbitration; protections for the use of antipsychotic and psychotropic drugs; and requiring an emphasis on person-centered care planning and provision of care.

In a time of increased attention on resident abuse and neglect, CMS's decision to rollback resident rights and protections in favor of reducing burdens is tone-deaf. These new final and proposed rules published last week are steps in the wrong direction. The needs of nursing home residents are significant. Residents' acuity level has increased, and the majority have some form of dementia. The increased prevalence of physical and cognitive impairments makes residents more at risk of abuse and neglect, as evidenced by the 2017 CNN investigative report that exposed widespread sexual assault in nursing homes across the country, including the rape of Maya Fischer's mother.[26] In addition, poor care, abuse, and neglect continue to be a problem nationwide as documented by studies and reports.[27]

We can do better. Thank you for holding this important hearing.

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[21] OIG, "National Background Check Program for Long-Term Care Providers: Assessment of State Programs Concluded Between 2013 and 2016," OIE–07–16–00160, April 22, 2019.

[22] 84 Fed. Reg. 34718 (July 18, 2019).

[23] 84 Fed. Reg. 34737 (July 18, 2019).

[24] 81 Fed. Reg. 68688 (October 4, 2016).

[25] Federal Register, Vol. 81, No. 192, October 4, 2016, 42 CFR Parts 405, 431, 447, 482, 483, 485, 488, and 489.

[26] Blake Ellis and Melanie Hicken, "Sick, Dying and Raped in America's Nursing Homes," CNN Reports, February 22, 2017.

[27] *Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries* (February 2014), OEI–06–11—00370. *Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 2009–2015.* Prepared by: Charlene Harrington, Ph.D., Helen Carrillo, M.S., University of California San Francisco, and Rachel Garfield, Kaiser Family Foundation.

QUESTIONS SUBMITTED FOR THE RECORD TO LORI SMETANKA

QUESTIONS SUBMITTED BY HON. CHUCK GRASSLEY

Question. What more should Federal or State agencies do to ensure that complaints of suspected abuse at nursing home are properly reported to law enforcement or Adult Protective Services agencies for investigation? Do you support the recommendations of the Office of Inspector General (OIG) and the Government Accountability Office (GAO) in this area?

Answer. The recommendations made by the Office of Inspector General and the Government Accountability Office in their recent reports (specifically GAO–19–671–T, June 2019; and OIG A–01–16_00509, June 2019) to CMS that it require the reporting of abuse and neglect, or potential abuse and neglect to law enforcement; issue clarifying guidance around abuse reporting; record and track incidents of potential abuse or neglect, including emergency room claims data; and monitor State Survey Agencies reporting of findings and suspicions of abuse to law enforcement, are long overdue and are supported by the National Consumer Voice for Quality Long-Term Care.

The findings of both studies highlighted the critical need for immediate action in order to protect residents of nursing facilities. Residents of long-term care facilities are, in many instances, dependent upon others for care and services, and many are living with cognitive impairment. They, and their families, rely on nursing facility staff, as well as government agencies charged with conducting oversight, to fulfill their statutory responsibilities—including enabling residents to achieve their "highest practicable mental, physical and psychosocial well-being."

Unfortunately, there have been numerous reports, studies, and articles over the years highlighting concerns about abuse in nursing facilities. In fact, in 2017 the HHS OIG was so concerned about incidents that may indicate potential abuse, which were being analyzed for the study released at this hearing, that it issued an "Early Alert" to CMS to notify the agency of possible widespread abuse, and to recommend immediate follow-up action. Consumer Voice supports the OIG recommendations to CMS to take action to ensure that incidents of potential abuse or neglect of nursing facility residents be identified and reported appropriately and in a timely fashion.

Also troubling, the OIG has found that CMS is failing to enforce the provisions of section 1150B of the Social Security Act, requiring facilities to report suspicions of a crime to law enforcement, stating that it is waiting for authority to enforce from HHS. These requirements became effective in 2011. Regulations requiring the reporting were not issued until 2016. Eight years after the effective date, CMS is still arguing that it requires new authority in order to enforce these provisions.

Failure to report abuse prolongs the victimization and suffering of those being abused and puts at risk other residents who are in contact with a possible abuser. Additionally, failure to report leads to significant delays or failures in investigations, reducing the odds of prosecution of the perpetrators, as appropriate.

Based on the OIG's findings, our recommendations are to:

- Direct CMS to implement the recommendations of the OIG and GAO related to tracking incidents of potential abuse and neglect, and reporting abuse and neglect, or potential abuse and neglect to law enforcement. Reporting requirements of surveyors to law enforcement should include prompt referrals to State Medicaid Fraud Control Units if there is evidence of falsification of records or significant concerns regarding neglect or abuse of residents in the facility, as described in the testimony of Keesha Mitchell, Ohio Office of the Attorney General, at the March 2019 Senate Committee on Finance hearing.
- Direct CMS to fully enforce the ACA's requirement for individuals to report possible criminal acts to law enforcement.
- Require the imposition of per day civil money penalties against the nursing home or other licensed entity for failure to report abuse or suspicions of a crime or for continuing to employ a worker against whom there is a reasonable suspicion of abuse.
- Define corporate entities as "covered individuals" under the Elder Justice Act.
- Require nursing homes to post a notice in a prominent place in the facility that employees are required to report to the State survey agency and law enforcement and are subject to fines for failure to do so.

Question. According to media reports, about 400 nursing homes in rural areas have closed or merged in the last decade. To what extent should we be concerned about this trend of rural nursing home closures? What options might we pursue in areas of the country in which nursing homes are at higher risk of closure?

Answer. The closing of nursing homes is almost always a concern as it displaces residents from their homes. A study on closures that the Consumer Voice released in 2016 found that the closure of a nursing home often resulted in residents being moved great distances from their families, friends, and communities; that the process was often chaotic; and that residents are at high risk of experiencing transfer trauma. In rural areas, the problems are often exacerbated because there are fewer alternate locations for residents, and also because of the impact on workers and communities.

States and the Federal Government need to proactively explore strategies for addressing the nursing home closures across the country that seem to be increasing. The nursing home industry has blamed the closures on low Medicaid rates. The reality, however, is not as clear-cut. Numerous reports highlight lack of managerial competence, mismanagement of funds, failure of States to adequately screen prospective owners for financial capacity or compliance history, and inadequate monitoring of facilities, particularly those showing signs of trouble or instability.

Recommendations include:

- Requiring States and CMS to aggressively enforce Federal requirements around nursing home closure and impose immediate penalties against owners/administrators who do not comply, including excluding an owner/operator from Medicare and Medicaid when the closing of a facility fails to comply with the Federal nursing home closure requirements.
- Establish minimum Federal criteria as a condition of Medicare and Medicaid certification for assuming ownership or management of nursing homes, including requiring States to audit such owners or managers for short and long-term financial capacity, managerial competence and compliance history.
- Requiring auditing of how nursing homes are spending the Federal dollars they receive.
- Strengthen closure requirements by requiring States to develop coordinated State teams focused on closure and relocation; requiring that the State Ombudsman have an opportunity to review and comment on the facility's closure plan prior to its approval by the State; and making available resources, such as civil money penalty funds, to support residents during the closure process.
- Require that owners/operators explore options such as sale of the facility or change in management prior to approving a closure.
- For facilities facing closure due to termination from Medicare or Medicaid, require CMS and State Survey Agencies to appoint a temporary manager, whenever possible, to take the necessary steps to bring a facility back into compliance without forcing residents to leave.

Question. What changes, if any, should we make to improve the Nursing Home Compare website or the government's Five-Star Rating System for nursing homes?

Answer. Consumers and potential consumers rely on the information presented on Nursing Home Compare and the Five-Star Rating System for making decisions (when possible) about nursing home placement and quality. It is important that the information made available be accurate, clear, and truthful. Currently, the ratings system relies on rankings from facility surveys, staffing data, and quality measures. Until recently, the staffing data was self-reported by the nursing homes. The Nursing Home Transparency Act required that CMS collect and use staffing data based on facility payroll records. Studies and data comparisons showed that prior to reporting the payroll-based data, nursing facilities over-reported the numbers of staff available to provide care for residents.

Currently, most of the quality measures data is also self-reported by the nursing facility. It is not uncommon for the quality measures scores to be higher than that reflected from the surveys and staffing data. And the method of calculation for the overall star ranking for a nursing facility frequently results in a higher overall ranking, due to the higher quality measure scores.

Recommended changes to the Nursing Home Compare website and the Five-Star Rating System include:

- Basing the calculations for star ratings using only auditable data, such as the survey reports and payroll-based staffing data. The quality measures should continue to be posted to Nursing Home Compare, but not included in the star rating calculations.
- Clearly identifying ownership information, including the corporations that own and/or operate the facilities.
- Identify facilities that are on the CMS Special Focus Facility list, as well as those that are Candidates for the Special Focus Facility list (candidates meet the same conditions as those selected for the list). Importantly, survey and certification funding must be substantially increased to expand the program. Consumer Voice strongly opposes allowing facilities that are currently rated as high performers (five stars) to be inspected less frequently. This is a highly dangerous precedent that would serve to begin to severely undermine the fundamental, long-established protocols of annual inspections for all nursing homes. To cite an analogy, it would be dangerous and unthinkable to decide to stop or delay inspecting planes that have good performance records.
- Indicate facilities that have been cited for abuse, neglect, or failure to report abuse or neglect.

Question. In addition to the recommendations in your testimony, what changes, if any, do you recommend that Congress make to the Elder Justice Act? Please identify any concerns with activities authorized under that statute, such as the long-term care ombudsman program, Adult Protective Services, or the Elder Justice Advisory Council.

Answer. The Elder Justice Act is important legislation that emphasizes resources and actions to prevent and respond to abuse and neglect of seniors. We urge Congress to reauthorize the statute and appropriate the funding necessary to implement the provisions, including that allocated for the Long-Term Care Ombudsman Program and Adult Protective Services.

Further recommendations include:

- Direct CMS to fully enforce the ACA's requirement (section 1150B of Act) for individuals to report possible criminal acts to law enforcement.
- Require the imposition of per day civil money penalties against the nursing home or other licensed entity for failure to report abuse or suspicions of a crime or for continuing to employ a worker against whom there is a reasonable suspicion of abuse.
- Define corporate entities as "covered individuals" under the Elder Justice Act.
- Require nursing homes to post a notice in a prominent place in the facility that employees are required to report to the State survey agency and law enforcement and are subject to fines for failure to do so.

Question. What options exist for nursing homes that struggle to recruit, hire, and retain qualified personnel to serve as certified nursing assistants?

Answer. It is in the interest of nursing facilities to comply with HHS findings that the threshold for not causing harm to residents is a minimum of 4.1 hours of direct nursing care per resident day (CMS, Abt Associates, "Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes," Report to Congress, 2001). It is also in the best interests of the overall health-care system that care in nursing homes be the best it can be. As well as the high human cost to poor care, inadequate staffing levels can result in the need for expensive—and avoidable—treatment and services, including preventable admissions and readmissions from nursing facilities to hospitals.

We recognize that many facilities struggle to recruit, hire, and retain qualified staff. It is incumbent upon nursing facilities to evaluate the experiences of their staff and incorporate practices for improving the working conditions in nursing facilities and offering advancement opportunities, including: paying living wages to staff, offering career ladders, establishing mentoring programs for new staff, providing flexible working schedules, strengthening training, ensuring effective supervision of staff, and recognizing and rewarding staff in meaningful ways.

The nursing home industry has indicated it requires an additional $6 billion in funding in order to appropriately staff nursing facilities to meet the needs of residents (response of Mark Parkinson, AHCA, to Senator Cortez Masto, Senate Committee on Finance hearing, July 23, 2019). Prior to allocating additional funds for

the industry, it is important that CMS be charged with analyzing how the money provided by taxpayers is spent—and there are several authorities included in the ACA that provide key tools for CMS to undertake this work—specifically section 6101, section 6104, and section 6106. Nearly three-quarters of payments for nursing facility care come directly from the Federal Government and from State governments. In 2017, Medicare spending in skilled nursing facilities was estimated at $28 billion; while Medicaid spending was estimated at $58 billion. We need assurances that money is spent wisely.

In 2007, when Congress conducted hearings on institutional changes to improve nursing home quality, prior to passage of the Nursing Home Transparency and Elder Justice Acts, it focused on the revelations about private equity groups and their diversion of funding from resident care to profits. The concerns about private equity and other corporations are greater than ever as they divest themselves of real estate and operations to companies with poor quality of care records and weak or unknown financial management ability.

Our recommendations are that:

- Congress should improve financial accountability of nursing homes by requiring audits of Medicare cost reports (section 6104 of the ACA), and transparency through detailed financial reporting that includes disclosure of finances regarding related-party companies and owners.
- Congress should enact a requirement for CMS to develop a medical-loss ratio for nursing homes that ensure that the bulk of taxpayer dollars are spent on resident care, not on administrative costs and profits.
- Congress should instruct CMS that annual reimbursement updates prioritize the need for SNFs to achieve staffing of 4.1 hours of direct care per resident per day (or higher), and any additional funds appropriated must be earmarked for staffing. Additionally, there must be adequate monitoring and enforcement to ensure the funds are properly spent.

Question. Should the Centers for Medicare and Medicaid Services upgrade its training curriculum for Federal or State regulators or others, and if so, in which areas? Should CMS or other agencies, such as the Administration for Community Living, develop additional training materials for nursing home personnel, and are there particular topics (*e.g.,* serving patients with dementia) which should be covered?

Answer. Adequate and comprehensive training for Federal and State regulators is critical for thorough and consistent implementation and enforcement of Federal requirements and standards. Additional training for regulators would be beneficial in such areas as detecting and reporting abuse and neglect, identifying harm, assigning scope and severity, and investigative practices.

There are already numerous resources and training programs for nursing home providers and personnel that have been developed by both government and private entities. To the extent that facilities need additional training, government agencies/programs that do not have regulatory jurisdiction over nursing homes (*e.g.,* Quality Improvement Organizations) and non-governmental entities (*e.g.,* private consultants, trade associations) can meet that need. With its limited time and funding, the work of the Quality, Safety and Oversight Group, and the Nursing Home Division, should be focused on enforcement of nursing home standards since they are entities with primary responsibility for regulatory oversight.

QUESTION SUBMITTED BY HON. JAMES LANKFORD

Question. Do you believe that facilities that report tax and detailed spending information have fewer instances of abuse? Oklahoma has seen nursing homes with complex ownership models and out-of-State owners. Have you noticed any correlation between ownership status and quality of care?

Answer. In 2007, when Congress conducted hearings on institutional changes to improve nursing home quality, prior to passage of the Nursing Home Transparency and Elder Justice Acts, it focused on the revelations about private equity groups and their diversion of funding from resident care to profits. The concerns about private equity and other corporations are greater than ever as they divest themselves of real estate and operations to companies with poor quality-of-care records and weak or unknown financial management ability.

Between 2003–2008, four of the 10 largest for-profit nursing home chains were purchased by private equity firms. Instead of improved financial stability, however, some of those chains have collapsed. *The Washington Post* reported that "under the ownership of the Carlyle Group, one of the richest private-equity firms in the world, the ManorCare nursing-home chain struggled financially until it filed for bankruptcy in March 2018. During the 5 years preceding the bankruptcy, the second-largest nursing home chain in the U.S. exposed its roughly 25,000 residents to increasing health risks"—including drug overdoses, pressure ulcers, and broken bones.

Currently, division of ownership and management is occurring among numerous affiliated entities that derive profits, but who are not responsible for the quality of care. Further, many of the decisions that affect care, including operational budgets and staffing levels, are made at the corporate level—yet CMS oversight has been limited to individual facilities. Change is needed and will require a comprehensive strategy that includes close monitoring and full use of available data about organizations and individuals who own and/or exercise significant influence over the finances and operations of individual nursing homes and chains.

We recommend that Congress establish a Federal "early warning system" to identify patterns of poor care and financial distress in nursing homes that can result in resident harm, bankruptcy and closure. Such a system would include monitoring data on owners and "additional disclosable parties" on an ongoing basis that is available in the Provider Enrollment, Chain, and Ownership System (PECOS) (or a subsequent replacement system) and comparing it with information about staffing that is available in the payroll-based journal database; information from State oversight of SNFs and NFs on their compliance with Federal safety and quality standards from the survey inspections, quality data derived from resident assessments, and complaint investigations submitted by residents. On a quarterly basis, findings would be referred to CMS, HHS OIG, and DOJ for action such as audits, increased oversight and coordinated enforcement; released to Congress; shared with State survey agencies, Medicaid Fraud Control Units, and State LTC Ombudsman Programs; and disclosed publicly.

QUESTIONS SUBMITTED BY HON. SHELDON WHITEHOUSE

Question. A 2015 Federal Government study found that less than 7 percent of people who'd signed arbitration agreements as part of credit card contracts understood that it meant they gave up their right to sue the company in the future.

Do you think that nursing home patients, who are already enduring a stressful and emotional situation, are in a position to fully understand what they are signing away?

Answer. Most residents and families are not aware of the arbitration provisions buried in admission agreements, nor do they fully understand the implications of signing such an agreement. Pre-dispute arbitration agreements are harmful and unfair to consumers. They prevent the consumer from making a truly informed decision about whether arbitration is the best course of action for their dispute or whether they should go to court. Asking a resident or representative to sign such an agreement takes advantage of the individual when they are at their most vulnerable. Most do not understand that they are signing their rights away.

Additionally, in the context of long-term care, these agreements treat potential neglect and abuse causing severe injuries, and even death, as comparable to a payment dispute or other negotiable issue.

The final arbitration rule published by CMS on July 18, 2019 ignores the disparity in bargaining power between the residents and the facilities. It is more a playbook for nursing homes to be able to claim they have disclosed arbitration protocols, and that they have "allowed" incoming residents and family members to sign a document saying they have been informed about the arbitration procedures, understand them and agree. This serves only the interest of nursing homes to claim, if challenged in court, that they followed the regulation's procedures and have the written signature of families who apparently agree that arbitration is fine and they "voluntarily" agree they will not pursue legal redress in court, should harm later occur. This is no choice at all, frankly, but portends only to strip millions of Americans of fundamental due process rights. Residents must be afforded a real choice about whether they would like to go to court, or enter into arbitration, *after* abuse, neglect, or other harm has occurred and a dispute arises.

Question. If a nursing home is abusing or neglecting patients, funneling any lawsuits into secretive private legal proceedings allows the nursing home to conceal a pattern of abuse. Correct? Don't other current and prospective patients have a right to know if a nursing home is mistreating its patients?

Answer. The secretive nature of arbitration proceedings allows nursing facilities to hide instances of poor care and abuse. There is no incentive for the facility to change its patterns and practices or improve conditions. Despite the findings of the GAO that citations for abuse deficiencies increased in the last few years, multiple studies have found that many States cite fewer serious deficiencies than actually occur and do not impose appropriate or effective remedies. Pre-dispute arbitration agreements deny long-term care consumers the option of holding facilities accountable for poor treatment, poor care and abuse through an open legal process. The well-being of all residents suffers as a result. Fewer consequences an allow substandard care to continue.

Because arbitration proceedings are confidential, potential residents and others are less likely to know about a facility's care problems. This deprives consumers of information they need when selecting a nursing facility. It also shields poor performing facilities from the negative impact on their reputation, public opinion and public pressure that could serve as a deterrent to substandard care.

PREPARED STATEMENT OF MEGAN H. TINKER, SENIOR ADVISOR FOR LEGAL AFFAIRS, OFFICE OF COUNSEL TO THE INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Good morning, Chairman Grassley, Ranking Member Wyden, and other distinguished members of the committee. Thank you for the opportunity to appear before you today to discuss the important topic of quality of care and safety of our Nation's Medicare and Medicaid beneficiaries.

Office of Inspector General (OIG) work has revealed widespread problems in providing safe, high-quality care to Medicare and Medicaid beneficiaries in many settings and ongoing failures to identify, report, and correct incidents of abuse and neglect when they occur. This morning, I will discuss our recent work focusing on abuse and neglect of Medicare beneficiaries, State Survey Agency response to nursing home deficiencies and complaints, and enforcement actions to address misconduct and grossly substandard care.

The three key take-a-ways from my testimony are:

- First, CMS, States, and providers should use data to ensure potential abuse and neglect is being identified.
- Second, CMS, States, and providers must ensure potential abuse and neglect is reported to enable oversight and prevention.
- Third, States must ensure deficiencies are corrected.

BACKGROUND

Approximately 1.4 million Medicare beneficiaries received care in skilled nursing facilities (SNFs) in 2016. Federal expenditures on nursing home care exceed $70 billion annually, including in 2017 $43 billion for Medicaid long-term care and $28 billion for Medicare post-acute and other skilled care. Most facilities providing these types of care are certified to serve as both nursing homes and SNFs. 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.

Ensuring that nursing homes meet Federal requirements for quality and safety is a shared Federal and State responsibility. State Survey Agencies (Survey Agencies) must conduct "surveys" (inspections) of nursing homes at least every 15 months to certify their compliance with these requirements. The Centers for Medicare and Medicaid Services (CMS) provides guidance regarding the survey process in its State Operations Manual (SOM) and Interpretive Guidelines. When Survey Agencies identify deficiencies during their surveys, nursing homes must submit correction plans, and Survey Agencies must verify that the facility corrected its deficiencies.

In addition, Survey Agencies must review all nursing home complaint allegations. A complaint survey can be conducted to investigate an allegation of noncompliance with Federal participation requirements, such as a nursing home providing im-

proper care or treatment to a beneficiary. Where the Survey Agency finds evidence of abuse or neglect it must make a referral to local law enforcement, the Medicaid Fraud Control Unit (MFCU) if appropriate, and the applicable licensure authority. CMS may also take enforcement actions to address nursing home deficiencies, including imposing civil monetary penalties or terminating the nursing home from Medicare and Medicaid.

ABUSE AND NEGLECT

Beneficiary safety and quality of care is a top priority for OIG, and we believe these goals can be better achieved through the effective harnessing of available data. The problems highlighted today are mirrored in other areas OIG has examined. For example, OIG's work on critical incident reporting at group homes showed that group home providers failed to report many critical incidents to the appropriate State agencies.[1] These critical incidents included death, physical/sexual assault, serious injuries, and missing persons. In addition, we released two reports earlier this month focused on hospice care.[2] OIG found that from 2012 through 2016, the majority of U.S. hospices that participated in Medicare had one or more deficiencies in the quality of care they provided to their patients. These deficiencies—much like the deficiencies highlighted elsewhere in my testimony—have a human cost on vulnerable beneficiaries and are subject to CMS oversight and enforcement action.

As we reported in an August 2017 Early Alert,[3] OIG reviewed hospital emergency room records from 2015 and 2016 for SNF residents whose injuries may have been the result of potential abuse or neglect in the SNF. We found 134 incidents of potential abuse or neglect across 33 States. For 28 percent of these incidents, we could not determine whether nursing home or hospital staff contacted local law enforcement despite State mandatory reporting laws requiring medical staff to do so. This Early Alert informed CMS that it had inadequate procedures to ensure that incidents of potential abuse and neglect at SNFs are properly identified and reported.

Abuse and Neglect Involving SNFs and Emergency Room Visits

In a June 2019 report,[4] we assessed the prevalence and reporting of incidents of potential abuse or neglect of Medicare beneficiaries residing in SNFs who had a hospital emergency room Medicare claim in calendar year (CY) 2016. **We determined that one in five of these high-risk claims were the result of potential abuse or neglect.**

> *Example:* A 72-year-old Medicare beneficiary with a history of throat cancer, recent throat surgery, and a nasogastric tube in place was transported to an emergency room (ER) and was diagnosed with aspiration pneumonia. The beneficiary's wife stated that her husband's nasogastric tube had not been suctioned well, and he was not given all of his scheduled tube feeds. In addition, records indicated that the beneficiary was given a meal tray with liquids despite a strict "nothing by mouth" order, putting the patient at risk for aspiration. The combination of the injuries suffered and the allegations made by the beneficiary's family gave reasonable cause to suspect potential neglect of this beneficiary.

A SNF must ensure that all incidents involving alleged abuse and neglect are reported immediately to the administrator of the facility and to the Survey Agency. **We determined that SNFs failed to report an estimated 6,608 instances of potential abuse or neglect (as identified in high-risk hospital ER Medicare claims) to the Survey Agencies in 2016.**

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[1] OIG, *Connecticut Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries* (A–01–14–00002), May 2016; OIG, *Massachusetts Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries* (A–01–14–00008), July 2016; OIG, *Maine Did Not Comply With Federal and State Requirements for Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities* (A–01–16–00001), August 2017; *Alaska Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities* (A–09–17–020016), June 2019.

[2] OIG, *Hospice Deficiencies Pose Risks to Medicare Beneficiaries* (OEI–02–17–00020), July 2019; *Safeguards Must Be Strengthened To Protect Medicare Hospice Beneficiaries From Harm* (OEI–02–17–00021), July 2019.

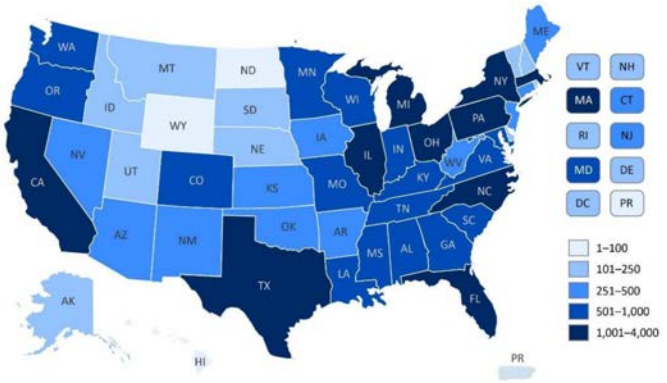
[3] OIG, *Early Alert: The Centers for Medicare and Medicaid Services Has Inadequate Procedures to Ensure That Incidents of Potential Abuse or Neglect at SNFs Are Identified and Reported in Accordance With Applicable Requirements* (A–01–17–00504), August 2017.

[4] OIG, *Incidents of Potential Abuse and Neglect at Skilled Nursing Facilities Were Not Always Reported and Investigated* (A–01–16–00509), June 2019.

Because of this failure to report, Survey Agencies could not review, prioritize, or conduct immediate onsite investigations, if necessary, to determine whether abuse, neglect, or other violations had occurred. Lastly, we determined that CMS does not require all incidents of potential abuse or neglect and related referrals made to law enforcement to be recorded and tracked in their complaint and incident tracking system.

Using Medicare Claim Data to Identify Potential Abuse and Neglect

In a June 2019 report,[5] we demonstrated that Medicare claims can be used to identify incidents of potential abuse or neglect, regardless of where the beneficiary resides. Further, our work showed that many of these incidents were not reported to law enforcement as required. **Medicare claims data identified more than 30,000 incidents of potential abuse or neglect.** In our review, we identified Medicare claims in all States that contained diagnosis codes indicating the treatment of injuries potentially caused by abuse or neglect of Medicare beneficiaries from January 1, 2015, through June 30, 2017.



Source: Appendix F, *CMS Could Use Medicare Data to Identify Instances of Potential Abuse or Neglect* (A-01-17-00513)

All of the diagnosis codes were assigned by the health professional who treated the Medicare beneficiaries. Most of the actual *incidents* that caused harm occurred in settings other than medical facilities. Only 10 percent were associated with incidents where the injuries occurred in a medical facility, like a nursing home. Healthcare workers were the likely perpetrators of incidents of potential abuse or neglect in about 7 percent of the claims.

Approximately 90 percent of the medical records identified by this analysis contained evidence of potential abuse or neglect. This evidence included, but was not limited to, witness statements and photographs. We estimated that 30,754 claims were supported by medical records that contained evidence of potential abuse or neglect.

Providers frequently failed to alert law enforcement to incidents of potential abuse or neglect. Approximately 27 percent of claims were not reported to law enforcement by mandatory reporters even though all States require certain individuals to report suspected abuse, neglect, or exploitation of vulnerable adults.

Section 1150B of the Act and the Federal Conditions of Participation (CoPs) contained in CFR title 42 for long-term-care facilities, such as nursing homes and SNFs, include reporting requirements for incidents of suspected abuse or neglect. For these facilities, covered individuals are required to report any reasonable suspicion of a crime, such as certain instances of abuse, neglect, or exploitation. The CoPs for hospitals require that hospitals follow State laws for mandatory reporting. Group homes and assisted-living facilities are covered by State regulations regarding the reporting of potential abuse or neglect, and their employees are generally covered by State laws for mandatory reporting.

[5] OIG, *CMS Could Use Medicare Data to Identify Instances of Potential Abuse or Neglect* (A–01–17–00513), issued May 2019.

A GUIDE FOR USING DIAGNOSIS CODES IN HEALTH INSURANCE CLAIMS TO HELP IDENTIFY UNREPORTED ABUSE OR NEGLECT

We believe that data forms the bedrock of oversight and ensures transparency and accountability. Data is an important means of ensuring the identification, reporting, and correction of incidents of abuse and neglect. Today we are releasing "A Resource Guide for Using Diagnosis Codes in Health Insurance Claims To Help Identify Unreported Abuse or Neglect," (guide) which explains our approach to using claims data to identify incidents of potential abuse or neglect of vulnerable populations. The guide synthesizes the methodologies that OIG developed in our extensive work on identifying unreported critical incidents, particularly those involving potential abuse or neglect.

The guide includes a flow chart showing key decision points in the process and the detailed lessons that OIG has learned using this approach. **We encourage CMS, States, providers, and other public and private-sector entities to use this guide to develop a process tailored to their specific circumstances and apply it to any vulnerable population they deem appropriate.** The sources of data could include Medicaid Management Information System claims data, private payor insurance claims data, or similar data sets. Analyzing the data can help identify individual incidents of unreported abuse or neglect, and patterns and trends of abuse or neglect involving specific providers, beneficiaries, or patients who may require immediate intervention to protect their health, safety and rights. The guide also provides technical information, such as examples of medical diagnosis codes, to assist CMS, States, providers, and others with analyzing claims data to help combat abuse and neglect.

CORRECTION OF DEFICIENCIES AT NURSING HOMES

State Survey Agencies perform surveys to determine whether nursing homes[6] meet the Federal Conditions of Participation. From 2015 to 2018, OIG completed audits of nine States and issued a consolidated report to CMS regarding whether the Survey Agency took appropriate steps to verify that nursing facilities had corrected identified deficiencies.[7] **We found that seven States failed to verify or maintain sufficient evidence that they had verified nursing homes' correction of deficiencies as required by Federal rules.** Specifically, for 47 percent of the sampled deficiencies (326 of the 700), these Survey Agencies did not obtain or maintain evidence of nursing homes' correction of deficiencies. If Survey Agencies certify that nursing homes are in substantial compliance without properly verifying the correction of deficiencies and maintaining sufficient documentation to support the verification of deficiency correction, the health and safety of nursing home residents may be at risk.

In addition, OIG recently issued a data brief[8] that analyzed nursing home deficiencies identified by State Survey Agencies across the Nation. Overall, we found that the number of deficiencies slightly increased from CYs 2013 through 2016, then slightly decreased in CY 2017. Also, the overall average number of deficiencies identified by standard and complaint surveys slightly increased from CYs 2013 through 2017, which would suggest that Survey Agencies identified more deficiencies per survey in CY 2017 than they did in CY 2013. **However, approximately 31 percent of nursing homes had a repeat deficiency, *i.e.*, a deficiency type that was cited at least five times in separate surveys.** Further, at least half of these nursing homes experienced an incident of a more serious deficiency, including incidents of substandard quality of care, actual harm, and immediate jeopardy to residents. The results of our data analysis raise questions as to whether the quality of care and services provided to nursing home residents improved during our review period.

OIG INVESTIGATIONS AND ENFORCEMENT: MISCONDUCT AND SUBSTANDARD CARE

OIG investigates potential criminal and civil violations and pursues administrative actions to hold accountable those who victimize residents of nursing homes. Allegations involving patient harm remain a top OIG enforcement priority. For example, following Hurricanes Irma and Maria, the OIG and other Federal and State

[6] Nursing homes can have both Medicare and Medicaid beneficiaries residing in them.

[7] OIG, *CMS Guidance to State Survey Agencies on Verifying Correction of Deficiencies Needs To Be Improved To Help Ensure the Health and Safety of Nursing Home Residents* (A–09–18–02000), February 2019.

[8] OIG, *Trends in Deficiencies at Nursing Homes Show That Improvements Are Needed To Ensure the Health and Safety of Residents* (A–09–18–02010), April 2019.

agencies undertook an investigation to review potential quality of care issues involving Medicare and Medicaid patients residing at long term care facilities. During the initial phase of this initiative, OIG along with other Federal and State authorities, visited more than 800 homes throughout Puerto Rico.

> *Example:* The investigation revealed that the owner of one of the facilities physically and verbally abused an 85-year-old female Medicaid beneficiary residing at her long-term-care facility. The owner verbally insulted the resident and punched her and hit her with a broomstick. The owner also negligently caused other patients residing at the facility to develop malnutrition and scabies. For patient safety, all residents were removed and transferred to other long-term-care facilities. The owner pleaded guilty to all five charges against her and was sentenced to 8 years of imprisonment to be served in home detention.

In other instances, facility-wide or chain-wide grossly substandard care has resulted in harm to patients. Such cases may result in False Claims Act resolutions or administrative actions, such as exclusion from participation in Federal healthcare programs. Patient neglect is a recurring issue in False Claims Act cases. **Allegations in these cases have included avoidable pressure ulcers; overmedication, 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.** 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 52 State Medicaid Fraud Control Units (MFCUs) that often have primary responsibility for enforcement of cases of abuse and neglect in health facilities, including nursing homes, as well as assisted living facilities.

ADDITIONAL CORRECTIVE ACTION IS NEEDED

To help ensure the health and safety of Medicare and Medicaid beneficiaries, the reports that I have referenced in this testimony, as well as numerous other OIG reports related to quality of care and nursing homes, have recommended that CMS take specific actions to improve this area of the program. A complete listing of significant unimplemented OIG recommendations as well as CMS's response to those recommendations can be found in our *Solutions to Reduce Fraud, Waste, and Abuse in HHS Programs: Top Recommendations.* The following is a list of some of our recommendations related to my testimony today:

- CMS should compile a list of diagnosis codes that indicate potential abuse or neglect, conduct periodic data extracts, and inform States that the data are available to help the States ensure compliance with their mandatory reporting laws.
- CMS should take action (*e.g.,* provide training, clarify guidance) to ensure that incidents of potential abuse or neglect of Medicare beneficiaries residing in SNFs are identified and reported.
- CMS should assess the sufficiency of existing Federal requirements to report suspected abuse and neglect of Medicare beneficiaries, regardless of where services are provided, and strengthen those requirements or seek additional legislative authorities if appropriate.
- CMS should improve its guidance to State Agencies on verifying nursing homes' correction of deficiencies and maintaining documentation to support verification.

CONCLUSION

CMS and law enforcement cannot adequately protect victims of abuse and neglect from harm if they do not first know the harm is occurring. Failing to leverage the data available represents a lost opportunity for CMS and public and patient safety organizations to identify and pursue legal, administrative, and other appropriate remedies to ensure the safety, health, and rights of Medicare and Medicaid beneficiaries.

HHS, CMS, and OIG are committed to the health and safety of beneficiaries. Despite this shared commitment, the data and findings that we are presenting today are extremely troubling and should cause all of us to redouble our efforts to protect the most vulnerable of our beneficiaries from these disturbing incidents. We need

to use all the tools at our disposal to effectively address the issues of abuse and neglect highlighted in my testimony. We believe that Medicare and Medicaid data is a critical tool and that CMS can do a better job of analyzing and sharing that data so that States can promote better health and safety outcomes and manage their programs more effectively. We created the guide that we are releasing today to support CMS, States, providers, and others in their efforts to curtail this ongoing problem of abuse and neglect of our most vulnerable beneficiaries.

Thank you for your ongoing leadership in this area and for affording OIG the opportunity to appear before you today.

QUESTIONS SUBMITTED FOR THE RECORD TO MEGAN H. TINKER

QUESTIONS SUBMITTED BY HON. CHUCK GRASSLEY

Question. Your testimony indicates that the Centers for Medicare and Medicaid Services (CMS) does not use every tool at its disposal to ensure that suspected abuse and neglect at skilled nursing facilities (SNFs) is properly identified, reported, and investigated. What specific legislative language might Congress adopt to ensure that CMS harnesses Medicaid and Medicare claims data or emergency room data to support its nursing home oversight, as the OIG has recommended?

Answer. Our report recommended that CMS compile a complete list of diagnosis codes that indicate potential physical or sexual abuse and neglect and use that complete list to conduct periodic data extracts of all Medicare claims containing at least one of those codes. CMS should then inform States that the extracted Medicare claims data are available to help States ensure compliance with their mandatory reporting laws. CMS did not concur with this recommendation. We note that CMS currently has the legal authority to analyze and share data with States. We do not have a specific legislative recommendation on this point but are available to provide technical assistance upon request.

Question. When reviewing hospital emergency room records for SNF residents whose injuries may have resulted from abuse or neglect, the OIG could not determine in 28 percent of such cases whether nursing home or hospital staff contacted law enforcement, as required by law. Does this point to the need for legislative or regulatory changes, and if so, what changes might Congress or CMS adopt to promote federally certified health-care providers' compliance with State mandatory reporting laws?

Answer. Currently, federally certified health-care providers (excluding hospice providers) are required by Federal regulations to comply with State mandatory reporting laws, and our audits have repeatedly demonstrated that these providers frequently do not appear to comply with these laws. However, these mandatory reporting laws generally only require providers to report when they have a reasonable belief/assumption that abuse or neglect has occurred. Broader reporting requirements could prompt providers to report potential abuse more comprehensively. We have asked providers why they did not report specific incidents of abuse or neglect during the course of our audits, and the universal response has been that the providers did not have a reasonable belief/assumption that abuse or neglect occurred. Incidents of potential abuse or neglect will continue to be underreported unless there is a reporting requirement that includes a detailed list of diagnosis codes that must be reported to appropriate authorities. Therefore, at a minimum, we believe that providers should be required to report any injury that they treat and subsequently diagnose using one of the diagnosis codes specific to abuse or neglect.

On the basis of the data we collected, we are concerned that abuse and neglect cases are not always being reported as required by law. In light of that finding, we recommended that CMS take steps to improve oversight and compliance with mandatory reporting laws. Specifically, we recommend that CMS take action to ensure that incidents of potential abuse or neglect of Medicare beneficiaries residing in skilled nursing facilities (SNFs) are identified and reported by working with the survey agencies to improve training for staff of SNFs on how to identify and report incidents of potential abuse or neglect of Medicare beneficiaries; clarifying guidance to define and provide examples of incidents of potential abuse or neglect; requiring the survey agencies to record and track all incidents of potential abuse or neglect in SNFs and referrals made to local law enforcement and other agencies; and monitoring the survey agencies' reporting of findings of substantiated abuse to local law enforcement. CMS concurred with our recommendations and provided details about

the actions it has taken and plans to take to ensure incidents of potential abuse or neglect of Medicare beneficiaries in SNFs are identified and reported.

Further, we recommend that CMS compile a complete list of diagnosis codes that indicate potential physical or sexual abuse and neglect and use that complete list to conduct periodic data extracts of all Medicare claims containing at least one of those codes. CMS could inform States that the extracted Medicare claims data are available to help States ensure compliance with their mandatory reporting laws. CMS did not concur with this recommendation.

Question. The OIG's June 2019 report indicates that 5,200 nursing homes with repeat deficiencies (*i.e.,* a deficiency type that was cited at least 5 times in separate surveys) had 12,700 repeat deficiencies in all. Serious deficiencies at these facilities mostly related to the Federal participation requirements for (1) ensuring that nursing homes are free of accident hazards, provide adequate supervision of residents, and provide adequate assistance devices for residents; and (2) providing care and services for the highest well-being of residents. What does this data reveal about CMS's oversight of nursing facilities? What options exist for CMS to promote greater corrective action at such facilities?

Answer. The data shows that a large number of nursing homes had a large number of repeat deficiencies. CMS generally relies on State survey agencies to oversee the nursing homes. Under an agreement with CMS, State agencies perform surveys to determine whether nursing homes meet specified program requirements, known as Federal participation requirements. During a survey, a State agency identifies certain deficiencies, such as a nursing home's failure to provide necessary care and services. Nursing homes are required to submit a plan of correction to address deficiencies, and the plan should include which measures the nursing home will put into place or which systemic changes will be made to ensure that the deficient practice will not recur. Our previous report, *CMS Guidance to State Survey Agencies on Verifying Correction of Deficiencies Needs To Be Improved To Help Ensure the Health and Safety of Nursing Home Residents* (A–09–18–02000), found that seven of nine State agencies did not always verify nursing homes' correction of deficiencies as required. Our previous report, *CMS Guidance to State Survey Agencies on Verifying Correction of Deficiencies Needs To Be Improved To Help Ensure the Health and Safety of Nursing Home Residents* (A–09–18–02000), found that seven of nine State agencies did not always verify nursing homes' correction of deficiencies as required. In this report, we made several recommendations to CMS to help ensure that State agencies verify nursing homes' correction of deficiencies.

Question. At my request, the OIG analyzed the use of psychotropic drugs at nursing homes nearly 2 decades ago. The OIG then reported that these drugs are generally being used appropriately, but where problems exist, they typically relate to inappropriate dosage, chronic use, a lack of documented benefit to the resident, and inappropriate duplicate drug therapy. The OIG also cited a concern about the lack of adequate documentation for residents' psychotropic drug use. To what extent, if at all, has the OIG carried out additional research in this area since then, and do we still have reason to be concerned about lack of documentation for SNF residents' psychotropic drug use? If so, do you have recommendations for Congress in this area?

Answer. In November 2001, OIG released a report, per your request, that found psychotropic drug use in nursing homes was generally appropriate. A subsequent 2011 OIG report, also per your request, evaluated atypical antipsychotic drug claims, a sub-class of psychotropic drugs, in the Medicare population. The findings showed:

- 83 percent of Medicare claims for atypical antipsychotics were associated with off-label conditions (*i.e.,* prescribing a medication for other than FDA-approved uses);
- 88 percent of claims for atypical antipsychotics were associated with a condition specified in the FDA black-box warning, indicating an increased risk of death for elderly patients with dementia;
- 51 percent of claims for atypical antipsychotics were paid in error (*e.g.,* a claim for a drug not used for a medically accepted condition), representing $116 million in Medicare spending; and
- 22 percent of claims for these drugs were not administered in accordance with CMS standards for unnecessary drug use in nursing homes.

In response to OIG's recommendations, CMS formed the National Partnership to Improve Dementia Care in Nursing Homes (National Partnership) in 2012 to reduce

the use of unnecessary antipsychotic medications in nursing homes. CMS reported success in reducing the number of residents receiving these medications by 39 percent nationally.

A 2014 CMS report acknowledged the need to continue to monitor psychotropic use. Concerns include drug substitution—for example, substituting anxiolytics or sedative/hypnotics for antipsychotics, as well as changes in the diagnoses nursing homes reported for nursing home residents (*https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-14-19.pdf;* page 37). Researchers share CMS' concerns. In 2019, CMS identified approximately 1,500 facilities that had not reduced the use of antipsychotic medications for long-stay nursing home residents. Additionally, a 2018 *Journal of the American Medical Association* article identified an increase in the use of mood stabilizers and benzodiazepines with a decrease in all other psychotropic medications. The authors suggest the increase in the use of these drugs may be a substitution for antipsychotics.

OIG plans to initiate a review of Medicare psychotropic drug use in nursing homes.

Question. After comparing employee data with criminal history record information for a random sample of 260 Medicare-certified nursing facilities, the OIG in March 2011 reported that 92 percent of these facilities employed at least one individual with at least one criminal conviction, and nearly half employed five or more individuals with at least one conviction. More recently, the OIG issued a report on the National Background Check Program for Long-Term Care Facilities. To what extent has CMS adopted the OIG's recommendations for improving background checks of nursing home employees since 2011? Does the OIG have additional recommendations for Congress or CMS in this area?

Answer. CMS has implemented all of OIG's recommendations from reports issued in 2011 and 2016. CMS concurred with the recommendation in our most recent report on the topic, issued in 2019.

In 2011, OIG recommended that CMS (1) develop background check procedures that clearly define the employee classifications that are direct patient access employees, and (2) work with participating States to develop a list of State and local convictions that disqualify an individual from nursing facility employment under the Federal regulation. CMS implemented these recommendations in 2015 *(https://oig.hhs.gov/oei/reports/oei-07-09-00110.pdf).*

In 2016, OIG recommended that CMS (1) continue working with participating States to fully implement their background check programs, (2) assist States to obtain legislative authority to conduct all required types of background checks on all required provider types, and (3) continue working with participating States to improve required reporting and effective oversight of the program. CMS developed a "National Background Check Program Interim Progress Report" to annually track State performance on OIG and CMS metrics; previously, CMS evaluated performance at the conclusion of each State's grant period, preventing the opportunity to address these issues during the grant period *(https://oig.hhs.gov/oei/reports/oei-07-10-00420.pdf).*

In April 2019, OIG recommended that CMS take appropriate action to encourage participating States to obtain necessary authorities to fully implement program requirements (*e.g.,* scheduling future grant payments based on implementation of requirements or issuing deficiency notices). CMS concurred with this recommendation but has not yet implemented it *(https://oig.hhs.gov/oei/reports/oei-07-16-00160.pdf).*

In July 2019, OIG released a study specifically examining State implementation of fingerprint-based criminal background checks for high-risk providers. In this study, OIG recommended that CMS (1) ensure that all States fully implement fingerprint-based criminal background checks for high-risk Medicaid providers; (2) amend its guidance so that States cannot forgo conducting criminal background checks on high-risk providers in certain circumstances; and (3) compare high-risk Medicaid providers' self-reported ownership information to Medicare's provider ownership information to help States identify discrepancies. CMS concurred with the first recommendation. CMS did not concur with the second and third recommendations *(https://oig.hhs.gov/oei/reports/oei-05-18-00070.pdf).*

Question. The OIG's 2019 report indicates that 10 categories of deficiencies account for 40 percent of all nursing home deficiencies. What conclusions can we draw

from this data, and does it point to the need for CMS to adopt specific reforms? If so, what do you recommend?

Answer. The top 10 categories of deficiencies provide information about the areas in need of the most improvement. The top 10 categories (which are listed in Figure 8 of the report cited in the question) are extensive and include maintaining areas free of accident hazards, adequate supervision of residents, and adequate assistance devices for residents; establishing infection control programs, preventing the spread of infection, and handling linens properly; providing care and services for the highest well-being; sanitary food procurement, storage, preparation, and service; developing comprehensive care plans; preserving drug regimens free from unnecessary drugs; sustaining proper drug records with labeling and storing of drugs and biologicals; upholding complete, accurate, and accessible resident records; retaining the dignity and respect of individuality; and investigating and reporting concerns involving allegations and individuals. Nursing homes, State survey agencies, and CMS can focus on taking action or implementing steps to help reduce the types of deficiencies from happening.

Question. The OIG's 2019 report indicates that just 10 States account for half of the deficiencies identified in its report. It also notes that the OIG did not account for possible variations in how States do inspections and identify deficiencies. How can we draw meaningful, nationwide comparisons from this data if States vary in how they conduct inspections? Should CMS or Congress do anything to promote greater uniformity, *e.g.,* through the issuance of guidance to State survey agencies?

Answer. In February 2019, OIG issued the report *CMS Guidance to State Survey Agencies on Verifying Correction of Deficiencies Needs To Be Improved to Help Ensure the Health and Safety of Nursing Home Residents* (February 7, 2019). In our report, we recommended that CMS (1) revise guidance to State agencies to provide specific information on how State agencies should verify and document their verification of nursing homes' correction of less serious deficiencies before certifying nursing homes' substantial compliance with Federal participation requirements; (2) revise guidance to State agencies to clarify the type of supporting evidence of correction that should be provided by nursing homes with or in addition to correction plans; and (3) strengthen guidance to State agencies to clarify who must attest that a correction plan will be implemented by a nursing home. CMS concurred with our recommendations, but, to date, the recommendations have not yet been implemented. These recommendations or other actions taken by CMS or Congress could help promote greater uniformity in the survey process.

Question. You testified that skilled nursing facilities didn't report over 6,000 instances of abuse or neglect to State inspectors in 2016. To your knowledge, has there been any follow up investigations into those cases?

Answer. The estimate of 6,608 instances of abuse or neglect not reported by SNFs to State inspectors in 2016 is the result of a statistical projection, and the status of those instances cannot be confirmed. OIG has not conducted a follow-up audit of our original results to determine the resolution of the 43 sample items involved in the projection that produced the 6,608. In the two abuse and neglect reports discussed at the July 23, 2019, hearing, we identified populations of potential abuse and neglect based on claims data. From the population in both reports we selected samples for more in-depth review. For the samples that were selected where there were indications of potential abuse and neglect, we referred these to State agencies and to law enforcement. We do not know the results of any follow-up activity by these entities or whether these instances were under investigation based on other referral sources.

QUESTION SUBMITTED BY HON. JAMES LANKFORD

Question. Have you found that there are fewer instances of abuse in home and community-based care than in institutionalized care such as nursing homes? How can HHS encourage families to access these services as an alternative or precursor to a nursing home?

Answer. OIG has not determined a rate of abuse or neglect for home and community-based care and institutionalized care that could be used as a basis to compare the two settings. OIG believes continuing work to promote quality and ensure safety of beneficiaries in home and community-based settings will facilitate informed decision-making about care placement for beneficiaries and their families. On the basis of our data, we know that most cases of potential abuse and neglect occurred

in settings other than medical facilities. Specifically, we determined that 12 of the 94 Medicare claims associated with incidents of potential abuse or neglect in our sample indicate that the abuse or neglect occurred at a medical facility. These medical facilities included nursing homes and SNFs (seven claims), group homes (three claims), long-term acute-care hospitals (one claim), and assisted living facilities (one claim). In addition, we determined that, of the 94 Medicare claims associated with incidents of potential abuse or neglect in our sample, 61 were associated with incidents that occurred at the Medicare beneficiaries' homes, and 16 occurred at other people's homes or public settings, such as parks and alleys. Unfortunately, from the data we can't make any conclusions about the prevalence of cases in home and community-based care vs. institutionalized care.

QUESTIONS SUBMITTED BY HON. TODD YOUNG

DATA ANALYTICS

Question. Ms. Tinker, in your testimony, you recommend that CMS, States and providers use data to ensure potential abuse and neglect is being identified.

What sources of data are needed to help identify potential abuse or neglect?

Answer. Based on our work, any robust source of claims data can be used to help identify potential abuse or neglect. To that end, in conjunction with the July 23, 2019, hearing, we released "A Resource Guide for Using Diagnosis Codes in Health Insurance Claims To Help Identify Unreported Abuse or Neglect" (guide) which explains our approach to using claims data to identify incidents of potential abuse or neglect of vulnerable populations. The guide synthesizes the methodologies that OIG developed in our extensive work on identifying unreported critical incidents, particularly those involving potential abuse or neglect. Any data sources containing information such as beneficiaries' names, Medicare identification numbers, Social Security numbers and diagnosis codes are needed to identify potential abuse or neglect. The Transformed Medicaid Statistical Information System (T–MSIS), National Claims History file (Medicare), the Automated Survey Processing Environment Complaints/Incidents Tracking System (ACTS), and the National Provider Data Bank (NPDB) are all sources of data that could be used to identify potential abuse or neglect.

Question. Are there new sources of data that are needed?

Answer. No. Existing sources can be used.

Question. Should CMS consider using data tools, like health analytics, to more accurately help identify these incidences—while keep providers and States accountable?

Answer. We believe that the guide presents a good roadmap for how to use claims data. We believe that CMS should use health analytics to more accurately help identify incidents of abuse or neglect. Specifically, we have developed an approach that uses the medical diagnosis codes included in Medicare and Medicaid claims data to target medical records for review. In many of our reports, we found our methodology to be an effective approach to help address unreported abuse and neglect. This approach can help identify (1) unreported instances of abuse or neglect, (2) beneficiaries or patients who may require immediate intervention to ensure their safety, (3) providers exhibiting patterns of abuse or neglect, and (4) instances in which providers did not comply with mandatory reporting requirements. Our guide outlining this approach can be found at *https://www.oig.hhs.gov/compliance/compliance-resource-portal/abuse-neglect-guide/index.asp?utm_source=website&utm_medium=asp&utm_campaign=abuse-neglect-guide*.

Question. In your testimony, you also describe the difficulties in identifying potential abuse and neglect.

But what can we do to prevent these incidences from occurring in the first place?

Answer. We believe that greater compliance with mandatory reporting requirements and the use of data analysis are important tools to help reduce and prevent abuse and neglect. Using data to conduct better oversight of mandatory reporting laws can help promote compliance with these requirements. Data analysis can also help identify problematic facilities or providers, and/or beneficiaries that might be at risk, and thus help target oversight and enforcement efforts to prevent future harms.

Question. Should we consider other data tools, like predictive analytics, to prevent abuse and neglect?

Answer. We believe the first step should be to effectively use the data that we have in a manner consistent with the guide we released. Other data tools, such as predictive analytics or trend analysis, could be used to identify potential abuse and neglect. The results of such analysis could be used to develop recommendations to improve or correct weaknesses identified by that analysis. If the data are thus effectively used, other more innovative practices may become apparent.

Question. With the issues you describe with data, would it even be possible at this point to consider data tools?

Answer. Yes, our results show that data tools are an effective means to identify unreported incidents of abuse and neglect. To that end, we issued our resource guide to suggest that our partners make better use of data tools to further program compliance and reduce abuse and neglect. We believe that the data can be very effectively used in accordance with the guide.

QUESTIONS SUBMITTED BY HON. RON WYDEN

BACKGROUND CHECKS

Question. One of the tools that is available to nursing homes to try to prevent abuse by staff is the use of background checks. In 2010, as part of the Affordable Care Act, Congress established the National Background Check Program (NBCP) for nursing homes. By law, the HHS Office of Inspector General (OIG) has been auditing this program and the results are enough to knock the wind out of you. According to one audit from this April, in eight of the 10 States that actually completed the program, nearly 80,000 employment applicants were found to be ineligible. In one State that fully implemented all the NBCP background checks—Alaska—8 percent of employment applicants were found to be ineligible based on these checks. A number of States in the program did not complete the program and some 20 States did not even bother to participate. How many States, regardless of their level of participation in the NBCP, have complete background check requirements for nursing employees, as defined by the ACA for the NBCP, and how many do not?

Question. Twenty-nine States have elected to participate in the voluntary National Background Check Program (Program). To date, OIG has evaluated the 21 States that completed their respective Programs as of July 31, 2018. The Program requires background checks for prospective direct patient access employees for nine types of long-term-care facilities or providers. Included as direct patient access employees are nurses and other care providers. Included as direct patient access employees are nurses and other care providers. OIG identified 13 requirements related to background checks and determinations of employee ineligibility to evaluate State progress. OIG has issued a series of reports on 'States' implementation of the Program once they have completed the program.

Of the 21 States that completed Program participation:

- Eight States fully implemented the 13 selected requirements: Alaska, the District of Columbia, Florida, Georgia, Minnesota, New Mexico, Rhode Island, and West Virginia. (Note: Because Georgia did not fully implement the 13 selected requirements until after the end of the grant period, the State is not credited in the OIG report for meeting all 13 selected requirements.)
- Six States implemented most of the 13 requirements: Connecticut, Delaware, Oklahoma, Michigan, Utah, and Nevada. (Note: Although Delaware and Oklahoma did not complete background checks for all 9 facilities and provider types, the States did fully implement the 13 selected requirements for nursing homes.)
- Seven States implemented only some of the 13 requirements: California, Illinois, Kentucky, Maine, Maryland, Missouri, and North Carolina.

Eight participating States have not yet completed Program participation and have not yet been evaluated: Hawaii, Idaho, Kansas, Mississippi, Ohio, Oregon, Puerto Rico, and Wisconsin.

SECTION 1150B IMPLEMENTATION

Question. The Elder Justice Act established new elder abuse reporting requirements for nursing homes (section 1150B of the Social Security Act). The law re-

quires immediate reporting of any reasonable suspicion of a crime committed against a nursing home resident. Enforcement measures included civil monetary penalties of up to $300,000. In 2017, the HHS OIG issued an "early warning" report, which pointed out that the Centers for Medicare and Medicaid Services (CMS) had never been given authority to enforce section 1150B. HHS never addressed this recommendation. On July 22, 2019, the day before the hearing, the HHS OIG reiterated this recommendation in its Report "Solutions to Reduce Fraud, Waste, and Abuse in HHS Programs: OIG's Top Recommendations." OIG stated "CMS should take immediate action to ensure that incidents of potential abuse or neglect of Medicare beneficiaries residing in SNFs are identified and reported. Among other things, CMS should continue to work with the HHS Office of the Secretary to receive the delegation of authority to impose the civil monetary penalties and exclusion provisions of section 1150B of the Social Security Act." Please explain why HHS OIG has repeatedly made this recommendation and provide any explanation HHS has given HHS OIG for failing to do so.

Answer. As we discussed during the hearing, lack of reporting is a significant problem. We continue to urge HHS and CMS to use every tool available to protect beneficiaries. One way they can do that is to make better use of the tools they do have, such as data analysis, to prevent abuse and neglect in the first place. As to 1150B, our report, *CMS Could Use Medicare Data to Identify Instances of Potential Abuse or Neglect* (June 12, 2019), notes:

> In June 2017, CMS began working with the HHS Office of the Secretary to receive the delegation of authority to enforce the Act section 1150B. CMS officials stated that they have not taken action under section 1150B because they have not identified instances in which a covered individual failed to report a crime, such as an incident of potential abuse or neglect of a Medicare beneficiary. CMS officials also acknowledged that the CMS State Operations Manual (SOM) did not include references to section 1150B until March 8, 2017; however, they noted that CMS had issued the "CMS State Survey Agency Directors' Letter" (S&C–11–30–NH) on June 17, 2011. This letter details the requirements and sanctions contained in section 1150B and instructs the State Survey Agencies, which fulfill certain oversight functions, to process reports received under section 1150B in accordance with existing CMS and State policies and procedures. CMS officials stated that they have taken additional actions to protect residents in nursing homes by adding section 1150B requirements to training courses and issuing supporting interpretive guidance and training to surveyors. During this audit, CMS has continued to work with the HHS Office of the Secretary to receive this delegation and on drafting regulations regarding the enforcement of section 1150B.

We would refer you to the Department for any updates to the foregoing.

QUESTIONS SUBMITTED BY HON. ROBERT MENENDEZ

Question. During the hearing, two reasons were presented to explain why more States who participated in the National Background Check Program (NBCP) did not successfully implement the required range of background checks: States' inability to pass necessary legislation and the need for increased funding to ensure appropriate infrastructure is in place at the State level.

Has OIG or GAO identified key barriers to States passing necessary legislation?

Answer. In the absence of a Federal statute, States need to enact legislation to be able to implement Program requirements when they do not have the necessary legislative authority prior to Program participation. We found that numerous States lacked the legislative authority to conduct background checks on all required facilities and provider types.

Because several States did not have the necessary legislative authority to fully implement background check programs, OIG recommended that CMS use incentives to encourage participating States to obtain necessary authorities to fully implement Program requirements. These incentives could include scheduling future grant payments based on implementation of requirements or issuing deficiency notices. CMS concurred with this recommendation and plans to implement it.

Question. Is there action Congress can take to incentivize States to pass legislation that would enable the program to be implemented?

Answer. In April 2019, OIG recommended that CMS take appropriate action to encourage participating States to obtain necessary authorities to fully implement Program requirements (*e.g.,* scheduling future grant payments based on implementation of requirements or issuing deficiency notices). CMS concurred with this recommendation but has not yet implemented it.

Question. On average, how much funding would a State need in order to ensure that the appropriate infrastructure was in place?

Answer. Estimates are difficult to provide as States began grant participation with different levels of infrastructure and resources. Changes to State infrastructure ranged from developing new systems to refining existing ones. The Program requires States to match 1 dollar for every 3 dollars in Federal funding to a maximum Federal contribution of $3 million. For States that implemented all 13 selected Program requirements by the end of their grant period, the amount spent varied greatly. For example, New Mexico used approximately $473,000 in State funds and $1.4 million in Federal funds, and Minnesota used $28.6 million in State funds and $3 million in Federal funds.

QUESTIONS SUBMITTED BY HON. SHELDON WHITEHOUSE

Question. One of the recent HHS OIG reports found that CMS failed to identify thousands of cases of potential abuse or neglect that may have occurred at skilled nursing facilities. I was disappointed to learn that CMS disagreed with HHS OIG's recommendation to use claims data to identify potential abuse or neglect. I am a strong believer in using the data we have to make our health care system work better, and I would hope CMS would agree with that sentiment.

What is your response to CMS's assertion that claims data is not timely enough to respond to potential issues of abuse or neglect in skilled nursing facilities?

Answer. We believe that the data are timely and can be effectively used. In our response to CMS's comments on both of our final reports (A–01–17–00503 and A–0116–00509), we maintained that the data are timely enough to address acute problems of potential abuse and neglect, including injuries of unknown source. For example, in our final report on potential abuse or neglect at skilled nursing facilities (A–01–16–00509), we acknowledged that providers have up to 12 months from the date of service to submit claims for services rendered. However, we noted that, on average, hospitals submitted the claims that were included in our sampling frame to the Medicare Administrative Contractor (MAC) in less than 30 days after the dates of service. In fact, hospitals submitted more than 80 percent of all claims included in our sampling frame to the MAC in less than 30 days after the dates of service and more than 90 percent of all claims included in our sampling frame in less than 90 days after the dates of service.

Question. Are there other data sources CMS could use to improve its response to abuse in neglect in skilled nursing facilities?

Answer. We believe that the Transformed Medicaid Statistical Information System (T–MSIS), National Claims History file (Medicare), the Automated Survey Processing Environment Complaints/Incidents Tracking System (ACTS), and the National Provider Data Bank (NPDB) are all sources of data that could be used to identify potential abuse or neglect. CMS should use all the data at its disposal to address the issue of abuse and neglect.

Question. Should Congress consider requiring CMS to leverage claims data to identify potential instances of abuse or neglect.

Answer. We defer to Congress in making that policy determination. But would note that CMS has the legal authority to leverage claims data to identify incidents of abuse or neglect. OIG has developed an approach, which we think CMS and others could replicate, that uses the medical diagnosis codes included in Medicare and Medicaid claims data to target medical records for review. In many of our reports, we found our methodology to be an effective approach to help address unreported abuse and neglect. This approach can help identify (1) unreported instances of abuse or neglect, (2) beneficiaries or patients who may require immediate intervention to ensure their safety, (3) providers exhibiting patterns of abuse or neglect, and (4) instances in which providers did not comply with mandatory-reporting requirements. Our guide outlining this approach can be found at *https://www.oig.hhs.gov/compliance/compliance-resource-portal/abuse-neglect-guide/index.asp?utm_source=website&utm_medium=asp&utm_campaign=abuse-neglect-guide.*

PREPARED STATEMENT OF HON. RON WYDEN,
A U.S. SENATOR FROM OREGON

The Finance Committee meets this morning to discuss what more can be done to protect seniors from abuse and neglect in nursing homes. Based on new reports from the Government Accountability Office and the Inspector General with purview over Medicare, there are two key issues for the committee to confront.

First, instances of physical, sexual, mental, and emotional abuse in nursing homes appear to be on the rise. Second, the Federal nursing home rating system does not accurately reflect the prevalence of that abuse. So when it comes to those cases, there are good nursing homes and there are bad nursing homes, and the government is failing to help consumers determine which are which.

So let me begin by outlining how the system is supposed to work. Everybody agrees that even one case of abuse in a nursing home is too many. Therefore, State agencies are in charge of conducting surveys of nursing homes and investigating reports of abuse. The Centers for Medicare and Medicaid Services is in charge of setting national standards and managing a nationwide rating system for nursing homes. State agencies and CMS are supposed to work in close communication with each other so that families can figure out which homes are safe. Today the committee will hear that the system is failing the elderly people it's supposed to protect.

GAO studied instances of abuse in nursing homes over a 5-year period from 2013 to 2017. Over that time, the recorded number of instances more than doubled. In a separate study, the HHS Office of Inspector General also concluded that thousands of cases of abuse in nursing homes are going unreported.

Then there's the issue of the broken rating system. The GAO study found abuse happened in homes of all ratings, top and bottom. A good rating did not indicate that a nursing home prevented abuse.

That brings me to the situation with my home State of Oregon. It was revealed during the GAO investigation that the State of Oregon went at least 15 years without reporting information on cases of abuse or neglect to CMS. Fifteen years' worth of records of physical, verbal, mental and emotional abuse—information that Oregonians needed to know in order to keep their loved ones safe—unavailable on the nursing home rating system.

Somebody in Oregon who wanted to find out if a particular nursing home had abusive staff would have better luck reading the local police blotter. Their State and Federal Government failed them.

In May, I wrote to CMS urging them to take two important steps. First, I said the Centers for Medicare and Medicaid Services ought to put a warning on its website that the nursing home rating system does not reflect cases of abuse in Oregon. And second, I wrote that they need to go back, work with the Oregon Government to find all this missing information and fix the rating system so that it's useful and accurate. Anything short of that, in my view, puts elderly Oregonians in danger. CMS has not yet responded. I ask unanimous consent that my letter to CMS be included in the hearing record.

I'll close on this. There's no question that there are good nursing homes across the land staffed by hard-working individuals who excel at their jobs. But not every home meets that standard.

In the cases these new reports have studied, vulnerable seniors—people living in nursing homes specifically because they cannot care for themselves—were exposed to unforgivable treatment. Thousands of incidents of physical, verbal, mental, and sexual abuse. Health-care needs unmet. Squalid living conditions. This cannot go on. People in Oregon and across the country have a right to know which homes are safe and which homes are not.

I believe there's an opportunity for Democrats and Republicans to work together to find solutions on this issue. I know Chairman Grassley is determined to work toward that end. I hope the committee is able to uncover some ideas today.

United States Senate

COMMITTEE ON FINANCE

WASHINGTON, DC 20510–6200

May 21, 2019

The Honorable Seema Verma
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Verma:

I am writing to express my concern regarding the recent Government Accountability Office (GAO) management report[1] that found the State of Oregon was not reporting cases of abuse in nursing homes to the Centers for Medicare and Medicaid Services (CMS). As a result, instances of abuse were not included as a part of the Federal Government's Nursing Home Compare tool and, although the instances of abuse were investigated by the state, CMS was not able to conduct its own abuse investigations or take related enforcement actions at Oregon nursing homes.

Seniors in nursing homes are among the most vulnerable to life-threatening consequences of abuse and neglect. As a co-director of the Oregon Gray Panthers and a member of the State Board of Examiners of Nursing Home Administrators, I saw the range of challenges facing older Oregonians, from those living in sordid conditions to those who struggled with activities of daily living.

Selecting a nursing home for a family member is a hard decision under the best of circumstances, which is why I pushed to establish a federal rating system to compare nursing homes. I am outraged that Oregon had not been reporting cases of abuse in nursing homes to CMS and that these cases had not been included in Nursing Home Compare since its very inception. Put simply, this has left Oregon families in the dark when they needed transparent and comprehensive information most. Not only has this deprived families of key facts about the quality of these nursing homes, it has also prevented CMS from identifying problems and taking enforcement actions.

For these reasons, I am calling on CMS to immediately make clear on the Nursing Home Compare website that Oregonians cannot rely on these ratings for nursing homes in our State. Although CMS committed in its agency comments to include a link on the Nursing Home Compare website to Oregon's Adult Protective Services in an effort to address this problem, no such link has been established to date. Furthermore, without clear disclosure of the missing abuse information and its potential impact on nursing home ratings, such a link, by itself, would not adequately inform site users of the flaws in the ratings.

It is also imperative that Oregon and CMS review all cases of abuse that were reported or referred to Oregon Protective Services, but not reported to CMS to determine if any additional enforcement actions can or should be taken. In its comments to GAO on March 29, 2019, CMS stated that regional CMS officials have directed the Oregon Department of Human Services to develop a plan for identifying any cases that require additional investigation. CMS needs to ensure that any such plan require a review of all unreported cases to determine whether additional investigations or enforcement actions by CMS are warranted. I am also requesting that you provide me a copy of this plan.

We appreciate your attention to this matter and your cooperation with this request. If you have any questions please contact David Berick with my Senate Committee on Finance staff at 202–224–4515.

Sincerely,

Ron Wyden
Ranking Member

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[1] *Management Report: CMS Needs to Address Gaps in Federal Oversight of Nursing Home Abuse Investigations That Persisted in Oregon for at Least 15 Years,* GAO–19–313R; April 15, 2019.

COMMUNICATIONS

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Statement of Michael Bindner

Chairman Grassley and Ranking Member Wyden, thank you for the opportunity to present our comments on this vital issue. This testimony is largely a restatement of our comments from the March 6th hearing, "Not Forgotten: Protecting Americans From Abuse and Neglect in Nursing Homes." We welcome any legislation on this topic, although we will take this opportunity to remind the committee of our proposals.

Our asset value-added tax and income surtax, which will fund withdrawals from the Medicare Trust Fund, which should be phased out when Baby Boomers have all retired.

Care for the sick and elderly was provided by families prior to the establishment of Social Security. Extended families provided shelter, income and health care because they had to. Allowing seniors to live independently freed the nuclear family to move without taking everyone with them. This led to a crisis in health coverage for those seniors left behind.

The logic of social insurance led to both Social Security, Medicare and Medicaid. This provided care for everyone regardless of accidents of birth or death. Without it, families with no surviving parents or grandparents would pay nothing, where only children might have to pay for both parents and their in-laws. This inequality still happens with housing and it strains many marriages.

Nursing home care is currently provided outside of Medicaid for the wealthy who can self-finance (although this does not necessarily guarantee quality if children or conservators get greedy), by spending down assets or through Medicaid once the assets are gone. Catastrophic insurance can be used as an alternative to spending down assets, although this is usually on available to wealthier individuals.

For most of us, nursing home care can be provided by state facilities, for profit facilities and religious (mainly Catholic) health systems.

Public facilities are being overcome by privatization efforts and often are dependent on local budgets. They are a big ticket item that seems easier to cut, although this is often penny wise and pound foolish, resulting in bad care and spurring privatization. Private facilities can be good or bad, depending upon rates charged and the quality of the staff. Sometimes one does not imply the other and Medicaid limits may lead to cutting corners, especially in staffing. Often, it takes a great deal of oversight by families to provide decent care, although they may just be witnesses to profit driven care which abuses their loved ones rather than being able to correct it.

Religious care is better because it usually lacks a profit motive and can, along with Medicaid funding, provide better care, although this may also lead to using members of the order who are not as well trained as professional staff. This meets the needs of many seniors, especially in rural states. Indeed, religious care holds a monopoly in some areas are for profit facilities close. Sadly, some systems in urban areas have the same bias to highly paid CEOs and lower paid staff.

In all systems, the need to save can lead to attempts to bust unions or to negotiate for substandard nursing wages or use of lower-skilled staff. Governmental oversight

helps matters, but budget cuts can leave such units understaffed with unreasonable caseloads. The choice between care for patients and oversight is a continual balancing act for CMMS and states.

Medicare for All would provide an ever growing pool of beneficiaries with Medicare benefits at Medicaid prices, with the difference being paid by either a payroll tax (employee and/or employer) or with an NBRT/SVAT, which would tax both labor and profit, as above. This is a change in funding, not a guarantee of quality. Cooperative health care, however, can provide better care for less money.

In the long run, employers, especially ESOPs and cooperatives, could replace health care services for both employees, the indigent and retirees and opt out of Medicare for All and receive an offset for NBRT/SVAT levies. This would allow them to hire their own doctors and arrange for hospital and specialist care with an incentive to cut cost and the ability to do so.

Expanding the number of employee-owned companies and cooperatives could be established with personal retirement accounts. Accounts holding index funds for Wall Street to play with will not help. Accounts should instead hold voting and preferred stock in the employer and an insurance fund holding the stocks of all such firms. NBRT/SVAT collections, which tax both labor and profit, will be set high enough to fund employee-ownership and payment of current beneficiaries. All employees would be credited with the same monthly contribution, regardless of wage. The employer contribution would be ended for health care at all levels.

ESOP loans and distribution of a portion of the Social Security Trust Fund could also speed the adoption of such accounts. Our Income and Inheritance Surtax (where cash from estates and the sale of estate assets are normal income) would fund reimbursements of the Trust Fund.

Thank you again for the opportunity to add our comments to the debate. Please contact us if we can be of any assistance or contribute direct testimony.

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Statement of Toby S. Edelman, Senior Policy Attorney

I am a Senior Policy Attorney in the Washington, DC. office of the Center for Medicare Advocacy, a national not-for-profit legal organization that focuses on assuring access to Medicare and high quality health care. I have represented nursing home residents and their interests in Washington, DC since 1977—more than 42 years.

The Inspector General's report last month documented the failure of nursing facilities across the country to report incidents of potential abuse or neglect of residents to their state survey agency in 2016.[1] Looking at a sample of high-risk emergency room claims submitted by hospitals to Medicare, the Inspector General estimated that 7,831 cases of potential abuse or neglect of residents had occurred. That's more than one claim for every two nursing facilities in the country. The Inspector General also found that facilities failed to report more than 84% of these incidents to the state survey agencies, as required by federal law.[2]

These statistics are appalling, but, unfortunately, they are not surprising to advocates for nursing home residents, who hear every day from residents and their families across the country about the many ways the promise and mandate of the 1987 Nursing Horne Reform Law are not being met.

No single action will prevent the abuse and neglect of residents. Multiple approaches are necessary. I offer four approaches that I believe would help reduce

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[1] Office of Inspector General, *Incidents of Potential Abuse and Neglect of Skilled Nursing Facilities Were Not Always Reported and Investigated,* A–01–16–00509 (June 2019), *https://oig.hhs.gov/oas/reports/region1/11600509.pdf.*

[2] 42 CFR § 483.12(c)(1). The facility must report abuse or incidents involving serious bodily injury immediately, but not less than 2 hours after the allegation is made, to the administrator and the state survey agency. The facility must report other incidents within 24 hours, 42 CFR § 483.12(c)(1). The facility must thoroughly investigate incidents, 42 CFR §§ 483.12(b)(2), 483.12(c)(2), and report the results of the investigation, within 5 days, to the administrator and state survey agency officials, 42 CFR § 483.12(c)(4).

abuse and neglect of residents and, more broadly, assure that all residents enjoy high quality of care and high quality of life.

First, unless and until we ensure that all facilities have sufficient numbers of well-trained, well-supervised, and well-compensated nursing staff, abuse and neglect will not be prevented and nursing homes will not provide residents with good care. The key single predictor of good quality of care and quality of life for residents is nurse staffing—both the professional registered nurses and licensed practical nurses and the paraprofessional nursing staff, the certified nurse assistants who provide the majority of direct hands-on care, often for minimum wage salaries. Nursing facilities do not have sufficient nursing staff.

The new payroll-based staffing information that the Centers for Medicare & Medicaid Services (CMS) now collects, as required by the Affordable Care Act, documents that nursing facilities nationwide have too few nursing staff to provide care to an ever-more frail and dependent population of residents. An analysis of these new data, published in a recent *Health Affairs* article, finds that "75 percent of nursing homes were almost never in compliance with what CMS expected their RN staffing level to be, based on residents' acuity."[3] Since these CMS expectations are based on a report that is nearly 20 years old, a time when residents were less disabled and had fewer care needs than today's residents, it is indisputable that most facilities today do not have sufficient nursing staff to meet residents' needs.

The new data also confirm what residents and families have known and told us for years—that facilities overstated their staffing levels under the prior system, have fewer staff on weekends, and boost their staffing in anticipation of surveys.

Unless and until we ensure that all facilities have sufficient numbers of well-trained, well supervised, and well-compensated nursing staff, nursing homes will not provide residents with good care.

Second, the survey and enforcement systems have failed to ensure that facilities meet federal standards of care and need to be significantly strengthened. Enforcement, now implemented on a facility-by-facility basis, should also evaluate facilities on a corporate-wide basis. The ongoing dismantling of meaningful enforcement needs to be reversed.

Surveys by state survey agencies are unannounced, but predictable. Many surveys are conducted at the same time every year, even though federal law since 1987 has authorized surveys on a nine to 15-month cycle,[4] and more surprise in the timing of surveys is possible. Even more troubling, more than 95% of problems found by surveyors are called "no harm"[5]—with the result that the facility usually faces no penalty. These no-harm deficiencies can include sexual assaults of residents,[6] broken bones,[7] maggots in a resident's scrotum[8]—all of these problems have been called no harm. The Center recently issued a report about "five star" facilities with no harm deficiencies.[9]

Yet even for the relatively small number of problems that are classified as actual harm or immediate jeopardy, facilities face few penalties.

Since 1987, federal law has required states and the federal government to have a range of sanctions to impose—including federal civil money penalties, denials of

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[3] Fangli Geng, David G. Stevenson, and David C. Grabowski, "Daily Nursing Home Staffing Levels Highly Variable, Often Below CMS Expectations," *Health Affairs* 38, N. 7 (2019): 195–1100.

[4] 42 U.S.C. §§ 1395i–3(g)(2)(A)(iii)(I), 1396r(g)(2)(A)(iii)(I), Medicare and Medicaid, respectively.

[5] CMS, *Nursing Home Data Compendium 2015 Edition,* Figure 2.2.e. Percentage Distribution of Scope and Severity of Health Deficiencies: United States, 2014, p. 48 (showing 0.9% of deficiencies as immediate jeopardy; 2.3% of deficiencies as actual harm), *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/nursinghomedatacompendium_508-2015.pdf.*

[6] *https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=235705&SURVEYDATE=09/06/2018&INSPTYPE=STD* (September 6, 2018 standard survey, Helen Newberry Joy Hospital LTCU, Michigan).

[7] *https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=055750&SURVEYDATE=10/31/2017&INSPTYPE=CMPL* (October 31, 2017 complaint survey, Amberwood Gardens, California).

[8] *https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=145736&SURVEYDATE=10/31/2017&INSPTYPE=CMPL* (October 31, 2017 complaint survey, Alden Town Manor Rehab and HCC, Illinois).

[9] "Elder Justice, What 'No Harm' Really Means for Residents," Vol. 2, Issue 2, *https://www.medicareadvocacy.org/wp-content/uploads/2019/06/Elder-Justice-Newsletter-Vol-2-No-2.pdf.*

payment for new admissions, directed plans of correction, monitors, and termination—and to impose more serious penalties for more serious problems and for problems that are not corrected or that recur over time.[10]

While enforcement has always been the least implemented part of the Reform Law, enforcement has now come to an almost complete halt. The Trump Administration has changed the enforcement system so dramatically[11] that nursing facilities face few (if any) or limited consequences, no matter how serious the problems and how poor the care. In the clearest example of the retreat on meaningful enforcement, federal guidance now calls for per instance civil money penalties,[12] rather than per day civil money penalties,[13] as required by the Obama Administration.

The average per instance civil money penalty is now less than $9,000.[14]

A recent administrative appeal involved a nursing facility's failure to assess a resident who experienced a significant change in condition and was in respiratory distress. For more than four hours, staff failed to take the man's vital signs or to call his physician. The facility finally took his vital signs and, an hour later, sent him to the hospital, where he died. Sustaining the deficiencies, which reflected failure to follow nursing standards of practice and the facility's own policies, as well as the federal regulations (all of which were consistent with each other), Administrative Law Judge Steven T. Kessel described the $10,000 per instance civil money penalty, less than half the maximum amount, as "trivial" for the facility's "egregious" noncompliance.[15] Judge Kessel noted that per day penalties would have been "many times what CMS determined to impose."

For many years, I have been looking at Special Focus Facilities—the small number of nursing facilities (now 88 nationwide) that states and CMS collectively decide are among the poorest performers—they have many very serious care problems and these problems persisted over a period of many years.[16] The point of the SFF program is to conduct more intense evaluation of the care that these facilities provide to their residents—two standard surveys a year instead of one—and to impose more significant penalties against them. Special Focus Facilities are expected to correct their problems and to stay in compliance or be terminated from Medicare and Medicaid. I have looked at this program over the years because if the enforcement system is not working effectively against the poorest performing facilities in the country, it cannot possibly be working against more marginal facilities.

Earlier this year, I looked at the 37 Special Focus Facilities that CMS identified as having not improved, as of January 19, 2019.[17] Twenty-eight of the 37 facilities were cited with actual harm or immediate jeopardy deficiencies in 2018, but only nine of the 28 had a CMP imposed against them. The CMP imposed against one Special Focus Facility exceeded $100,000, but the remaining eight CMPs ranged

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[10] 42 U.S.C. §§ 1395i–3(h), 1396r(h), Medicare and Medicaid, respectively.

[11] Jordan Rau, "Trump Administration Eases Nursing Home Fines in Victory for Industry," *The New York Times* (December 24, 2017), *https://www.nytimes.com/2017/12/24/business/trump-administration-nursing-home-penalties.html?searchResultPosition=1;* Toby S. Edelman, "Deregulating Nursing Homes," *Bifocal* (publication of the American Bar Association Commission on Law and Aging), Vol. 39, Issue 3 (December 4, 2018), *https://www.americanbar.org/groups/law_aging/publications/bifocal/vo1--39/issue-3--february-2018-/DeregulatingNursingHomes/.*

[12] CMS, "Final Revised Policies Regarding the Immediate Imposition of Federal Remedies," QSO 18–18–NH (June 15, 2018), *https://www.ems.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO18-18-NH.pdf* (making final CMS, "Revised Policies regarding the Immediate Imposition of Federal Remedies—FOR Action," S&C: 18–01–NH (October 27, 2017), *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-18-01.pdf.*

[13] CMS, "Mandatory Immediate Imposition of Federal Remedies and Assessment Factors Used to Determine the Seriousness of Deficiencies for Nursing Homes," S&C: 16–31–NH (July 22, 2016, revised July 29, 2016), *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-16-31.pdf.*

[14] Jordan Rau, *Kaiser Health News,* "Trump Administration Cuts the Size of Fines for Health Violations in Nursing Homes," National Public Radio (March 15, 2019), *https://www.npr.org/sections/health-shots/2019/03/15/702645465/trump-administration-cuts-the-size-of-fines-for-health-violations-in-nursing-hom.*

[15] *St. John of God Retirement and Care Center v. CMS,* DAB CR5290 (April 12, 2019), *https://www.hhs.gov/about/agencies/dab/decisions/alj-decisions/2019/alj-cr5290/index.html.*

[16] CMS, "Special Focus Facility (SFF) Initiative," *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/SFFList.pdf.*

[17] "There's Nothing Special About How CMS Treats Special Focus Nursing Facilities" (CMA Alert, February 14, 2019), *https://www.medicareadvocacy.org/theres-nothing-special-about-how-cms-treats-special-focus-nursing-facilities/.* The full report is at *https://www.medicareadvocacy.org/report-theres-nothing-special-about-how-cms-treats-special-focus-nursing-facilities/.*

from $10,400 to $53,089 and averaged $19,616.50. In all instances, the CMPs imposed against the nine facilities were far lower than the CMPs that had been imposed against them before they were identified as Special Focus Facilities. For example, one Colorado facility had a CMP of $11,267 imposed in June 2018 for 11 deficiencies, including one immediate jeopardy deficiency, but CMPs totaling $191,732 in July 2017 for 15 deficiencies, including one harm-level deficiency and one immediate jeopardy deficiency.[18]

More recently, I looked at the "graduates" of the SFF program, identified on CMS's May 2019 list.[19] Six of the 21 graduates were cited with harm and immediate jeopardy deficiencies in 2018.

One of the graduates was cited with three immediate jeopardy deficiencies, one at each of three complaint surveys and each of which resulted in a resident's death. Since fewer than 2–3% of problems are called immediate jeopardy (more than 95% of problems found by surveyors are called "no harm"),[20] this facility appeared to have serious problems in providing care to its residents.

One immediate jeopardy deficiency was based on the facility's failure to monitor residents who were known to wander. One resident left the facility without the staffs knowledge on December 30, 2017 and "was found dead outside an opened exterior kitchen door in sub-zero weather."[21] Another resident choked to death[22] and a third resident died after falling twice from a broken mechanical lift sling and suffering a brain bleed.[23] CMS did not impose a civil money penalty for any of these deficiencies, but imposed denial of payment for new admissions (of unknown duration), a different remedy, for the choking death.[24]

The facility also had problems with nurse staffing. The federal website did not report staffing levels for the facility. The icon on Nursing Home Compare indicates that the facility may not have submitted auditable staffing data or may have reported "a high number of days without a registered nurse."

The facility's record in 2018 does not meet the criteria CMS sets for graduation from the Special Focus Facility program—"These nursing homes not only improved, but they sustained significant improvement for about 12 months (through two standard inspections)."[25]

The survey and enforcement systems need to be strengthened to cite deficiencies accurately and to impose appropriate sanctions so that facilities remain in compliance with federal standards of care.

Third, Congress cannot rely solely on public information to improve nursing home quality. Information on the federal website Nursing Home Compare needs to be accurate, comprehensive, and transparent, but public information, while

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[18] *http://www.medicare.gov/nursinghomecompare/profile.html#profTab=5&ID=065248&state=CO&lat=0&lng=0name=BETHANY%2520NURSING%2520&2526%2520REHAB%2520CENTER&Distn=0.0* (listing CMPs). June 28, 2018 immediate jeopardy supervision deficiency, standard survey, at *https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=065248&SURVEYDATE=06/28/2018&INSPTYPE=CMPL* (pp. 28–36); July 18, 2017 complaint survey, sexual harassment, at *https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=065248&SURVEYDATE=07/18/2017&INSPTYPE=CMPL)* (pp. 1–9).

[19] "Special Report—'Graduates' from the Special Focus Facility Program Provide Poor Care" (CMA Alert, June 20, 2019), *https://www.medicareadvocacy.org/graduates-from-the-special-focus-facility.program-provided-poor-care/*.

[20] CMS, *Nursing Home Data Compendium 2015 Edition,* Figure 2.2.e. Percentage Distribution of Scope and Severity of Health Deficiencies: United States, 2014, p. 48 (showing 0.9% of deficiencies as immediate jeopardy; 2.3% of deficiencies as actual harm), *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/nursinghomedatacompendium_508-2015.pdf.*

[21] *https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=145924&SURVEYDATE=01/09/2018&INSPTYPE=CMPL,* pp. 1–4 (January 9, 2018 complaint survey, Champaign Rehab Center, Illinois).

[22] *https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=145924&SURVEYDATE=03/06/2018&INSPTYPE=CMPL,* pp. 1–3 (March 6, 2018 complaint survey, Champaign Rehab Center, Illinois).

[23] *https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=145924&SURVEYDATE=03/28/2018&INSPTYPE=CMPL,* pp. 1–5 (March 28, 2018 complaint survey, Champaign Rehab Center, Illinois).

[24] *https://www.medicare.gov/nursinghomecompare/profile.html#profTab=0&ID=145924&state=IL&lat=0&lng=0&name=CHAMPAIGN%2520REHAB%2520CENTER&Distn=0.0* (site visited July 19, 2019).

[25] CMS, Special Focus Facility ("SFF") Program (updated June 27, 2019), *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Downloads/SFFList.pdf.*

important and necessary, is not sufficient. We cannot expect a resident—for example, an 85-year old widow with dementia who cannot speak and has multiple physical and medical conditions and no family in the area—to use the information to choose a facility or monitor her own care or complain to an ombudsman or the state survey agency.

A market-based approach to regulating nursing homes cannot be the sole approach to ensuring quality. The Nursing Home Reform Law describes the Secretary's "duty and responsibility . . . to assure that the federal standards of care, and their enforcement, are adequate to protect residents' health, safety, welfare, and rights" and to "promote the effective and efficient use of public moneys."[26] Federal law mandates appropriate substantive standards, effectively enforced.

Finally, states must establish and enforce meaningful standards for who is eligible to operate a facility (*i.e.*, receive a state license) and, independently, CMS must establish and enforce meaningful standards for who is eligible to receive Medicare and Medicaid reimbursement for care (*i.e.*, receive federal certification). At present, ownership and management of nursing facilities, often divided among multiple companies,[27] appear to shift with little public information and insufficient public oversight.

The collapse of Skyline Healthcare last year was the most visible and vivid example of the problem of allowing companies without adequate financial and management resources to take over facilities. On July 19, 2019, NBC Nightly News broadcast an investigative report on Skyline, its collapse, and the impact on residents and their families.[28] This New Jersey company had a handful of facilities, but then, beginning in about 2016 or 2017, began to manage facilities across the country, primarily facilities that large chains, including Golden Living and Manor Care, decided not to operate any longer. In a period of little more than a year, Skyline Healthcare began operating between 100 and 120 facilities in eight states across the country. Then, within a similarly short period, it stopped meeting payroll and paying vendors.[29] States went to court to get authority to take over the facilities—the legal term is receivership—in order to make sure that residents received care, food, medicine, and supplies.

While other companies had gone into bankruptcy before and other owners had abandoned facilities before, there had never been such a large collapse, affecting so many states, so many facilities, and so many residents and staff. Skyline's collapse brought attention to the problem of who owns and who manages facilities—and whether are they qualified and competent to do so.

The Philadelphia Inquirer describes changes in the nursing home industry that led to this crisis for residents, families, communities, and states:

> The nursing home industry in recent years has been engulfed in wholesale changes in operators as Golden Living and other large companies, often

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[26] 42 U.S.C. §§ 1395i–3(f), 1396r(f)(l), Medicare and Medicaid, respectively.

[27] Joseph E. Casson, Julia McMillen, "Protecting Nursing Home Companies: Limiting Liability through Corporate Restructuring," *Journal of Health Law,* Vol. 36, No. 4 (Fall 2003).

[28] "NBC News Investigation: Nursing home chain collapses amid allegations of unpaid bills, poor care" (July 19, 2019), *https://www.nbcnews.com/nightly-news/video/nbc-news-investigation-mursing-home-chain-collapses-amid-allegations-of-unpaid-bills-poor-care-64181829714;* Laura Strickler, Stephanie Gosk and Shelby Hanssen, "A nursing home chain grows too fast and collapses, and elderly and disabled residents pay the price," NBC Nightly News (May 19, 2019), *https://www..nbcnews.com/health/aging/nursing-home-chain-grows-too-fast-collapses-elderly-disabled-residents-n1025381.*

[29] Harold Brubaker, "Questions about Willow Terrace owner after nursing home collapse in Nebraska and Kansas," *Philadelphia Inquirer* (April 12, 2018), *https://www.philly.com/philly/business/questions-about-skyline-healthcare-after-nursing-home-collapse-in-nebraska-and-kansas-20180412.html;* Lindy Washburn, "Thousands of nursing home patients nationwide affected by NJ company's financial trouble," *Northjersey.com* (April 16, 2018), *https://www.northjersey.com/story/news/watchdog/2018/04/16/thousands-nursing-home-patients-could-affected-fast-growing-nj-nursing-home-company-trouble-nebraska/493643002/;* Nebraska Department of Health and Human Services, "Nursing, Assisted Living Facilities Placed in Receivership to Protect Health and Safety of Residents" (News Release, March 23, 2018), *http//dhhs.ne.gov/News%20Release%20Archive/Nursing,%20Assisted%20Living%20Facilities%20Placed%20in%20Receivership%20to%20Protect%20Health%20and%20Safety%20of%20Residents.pdf#search=Nursing%2C%20Assisted%20Living%20Facilities%20Placed%20in%20Receivership%20to%20Protect%20Health%20and%20Safety%20of%20Residents;* Kansas Department for Aging and Disability Services, "KDADS Seeks to Take Over Management of 15 Kansas Nursing Homes" (News Release, March 28, 2018), *https://www.kdads.ks.gov/media-center/news-releases/2018/03/29/kdads-seeks-to-take-over-management-of-15-kansas-nursing-homes.*

> under regulatory and financial pressure, abandon the business and lease bunches of facilities over to firms that emerge from nowhere.[30]

States and CMS cannot allow "firms that emerge from nowhere" to operate nursing facilities. Meaningful standards of ownership and management are critical and these standards must be effectively enforced.

Not all facilities provide poor care, of course, but too many do. Preventing abuse and neglect of residents and improving quality of care and quality of life in nursing facilities for all residents require multiple efforts, simultaneously made—improving staffing, strengthening survey and enforcement processes, and making sure that individuals and companies that own and manage nursing facilities are prepared and competent to provide good care. Residents and their families and taxpayers deserve no less.

STATEMENT SUBMITTED BY KENDRA COOPER,
ELDER ADVOCATE/MA SILVER LEGISLATURE

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Chairman Grassley, Ranking Member Wyden, and distinguished Members of the Committee, thank you for providing me this opportunity to present my concerns. For over 10 years, I have been a strong advocate for elders to age in place in their homes. Though this is the goal of many of our senior adults, too often elders lose their homes and properties, assets and civil rights in a governmental and judicial system fraught with gaps in protections from financial exploitation and abuse. Elders are caught in a healthcare system geared towards convenience and profitability of the facilities and pharmaceuticals over the needs of elders and their families. This abuse often involves collusion of multiple parties and entities and, when the elder's assets are depleted and the profitability no longer beneficial for the collective abusers, the now expendable elder dies. How does this happen? The following three cases illustrate common patterns of abuse: isolation, intimidation, coercion, misrepresentation and exploitation.

Case 1: A legally blind cellist, in her 90s and still active in her community who exercised three times weekly at CURVES and lived independently in her Massachusetts home, was targeted by a sweetheart scammer/trusted church deacon who, in conjunction with a major international finance company, attorneys, realtors, engineers and medical staff, conspired to gain control of the elder, her assets and the property where she lived, developable acreage within a mile of the local train station. Though a MA Trust was in place and the woman's clear intent was to age in place, the trust terms were ignored by the MA courts; CDs and stocks were transferred without medallion signature to a finance company which falsely claimed the trustee had resigned or had been removed by the elder.

In hindsight, Elder Protective Services and law enforcement lacked the training and interest to spot and address this financial exploitation, the foundation for which took years to implement around the elder, unknown to the family. These governmental agencies and the judiciary contributed to the abuse as well, through restraining orders (later vacated) and costly protracted court processes.

When in 2011 the elder was diagnosed in MA with pneumonia, but led to believe it was simply a bad cold, she was driven by the sweetheart scammer, under the guise of a long weekend trip 400+ miles to northern Maine. She was immediately hospitalized within hours of her arrival and, though she recovered within weeks from the pneumonia, she was never allowed to return to Massachusetts.

Instead, based upon assessment of a Maine speech pathologist, the elder was determined to have dementia and placed on antipsychotics and opioids. This speech pathologist later admitted he was unaware the elder was legally blind when he evaluated her for dementia. The Maine medical doctor who signed guardianship papers never examined the elder for dementia, relying on the speech pathologist's evalua-

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[30] Harold Brubaker, "Questions about Willow Terrace owner after nursing home collapse in Nebraska and Kansas," *Philadelphia Inquirer* (April 12, 2018), *http://www.philly.com/philly/business/questions-about-skyline-healthcare-after-nursing-home-collapse-in-nebraska-and-kansas-20180412.html.*

tion; both MA and ME guardianship requirements stipulate *examination and evaluation* by a medical doctor for incapacity.

Even though both MA and ME had adopted the *Adult Guardianship and Protective Proceedings Jurisdiction Act (AGPPJA),* a Guardian ad Litem, Special Visitor and eventually a Guardian and Conservator were appointed by the Maine Probate Court.

Isolation was achieved by creating distance from Massachusetts family, removing her cello and controlling the phone and mail. The elder's telephone by the bed was connected to a cell phone modem under the cabinet which was on the Guardian's cell phone plan, giving the Guardian a record of every call and its length, to and from the elder. Sometimes the modem would be unplugged, rendering the telephone on the night table useless.

Initially, in Maine, the elder's assets funded an assisted living, a rehab and the nursing home. When the Guardian went on vacation, the legally blind elder was placed in a locked ward where her wrist was injured when she was shoved by another resident. Augusta authorities claimed that they could not release the results of their investigation of that incident to MA family because they had found no fault by the facility.

When the elder's assets were depleted in October 2014 and the elder was no longer a lucrative private pay resident, within weeks of going on MaineCare, a family member who happened to get through to her on the phone that morning, noted her slurred voice and contacted the nurse's station. She nearly died of an overdose from multiple drugs (including fentanyl) administered at the nursing home but, records show, these drugs were approved and signed for by the Guardian.

Though Maine Adult Protective Services and Division for the Blind were aware of the case, on orders of the Guardian, the elder received no services for her blindness the 5 years she lived in Maine, even though she had been receiving services in her MA home from Mass Eye and Ear Infirmary.

In Maine, Probate judges are elected and serve part time. The attorney simultaneously represented the elder also represented the Guardian, the Conservator, the assisted living, the rehab and the nursing home. This same attorney, in writing, advised the eider's local oral surgeon not to communicate with MA family who were concerned that unnecessary antipsychotics were causing rapid deterioration of the elder's teeth. The Guardian refused to fund further dental care.

Following the elder's near death overdose, a hearing was held but, instead of the Judge ordering improved oversight of the elder and coordinating her return to Massachusetts, he removed elder's MA family's access to her medical records. This Probate decision was appealed to the Maine Supreme Judicial Court (ME SJC), citing the improper award of Guardianship based upon insufficient evaluation of dementia and incapacity by a speech pathologist. Months later in October 2015, the ME SJC ruled the Appeal "untimely" and that there was no abuse of discretion by the court in removing access to the medical records.

After the SJC decision, there was no financial benefit to keeping the elder alive, since anyone on MaineCare could now fill her nursing home bed. Doctor's Progress Notes obtained after the eider's death show that, around Christmas 2015, a favorite time of year when the elder cellist in her previous life would be performing, state that the elder was "mean and nasty to staff" and she wouldn't take medication for a UTI (which often results in delirium). The Guardian determined it was the "end of the line," though the elder did not have a terminal disease. In January 2016, the eider's medications, including her heart and thyroid medicine, were removed and she was administered increasing levels of morphine subcutaneously (injected under her skin) with permission and at the direction of the Guardian and full knowledge of the facility doctor. The elder died at the facility March 2, 2016. An autopsy was *not* conducted, according to the Maine Medical Examiner's office, because her death was determined to be of "natural causes" based upon her age and, allegedly, a reading of the records. The facility doctor signed the death certificate.

Case 2: Massachusetts elder in her 60s, living independently in her Boston condominium, fell and went to rehab. Through medical records obtained after her death, her family learned that she was ready to return home with services but she instead was diagnosed with "alcohol induced dementia" (though family insists she did not drink alcohol) and given antipsychotics. She remained several years at the facility and even was included in studies and experiments without her family's knowledge or permission. Her assets eventually were depleted and a MassHealth lien was

placed on her condo, unbeknownst to the elder and her family. Following her death, family discovered the lien and questioned the amount claimed in recovery by MassHealth. Though her property has been sold now, the case is still in litigation and raises serious questions about failure of MassHealth to follow Federal requirements regarding recovery and placing liens on homes of modest value.

Case 3: An active but hard-of-hearing elder in her 90s, residing in independent living, swimming weekly and regularly exercising, who followed the stock market, used an iPad and is on Facebook, suffered a stroke which affected her left side but not her cognition. Shortly after she moved to rehab, in the night she was manhandled while using the bedpan and a single staff member moved her, injuring her hip. The elder was vocal regarding her needs, making excellent progress in PT for her stroke and informed the family of that night's events. Family requested the Care Plan and Progress Notes but found two days (including the day/night of incident) omitted from the record and the Care Plan had inaccuracies and omissions. Access to the Mobilex scan of the hip taken following the incident for a second opinion reading was also obstructed. Some family members were in fear that the facility staff would "take it out" on the elder if family asked questions and pushed for more complete records. Recently the rehab doctor prescribed Tramadol for the elder, raising some family concerns that the eider's mental status may deteriorate as a result. Family hired daytime caregivers to be their "eyes and ears" and relieve the rehab staff.

Conclusion: Many parties benefit when an elder, private pay or not, is purposefully misdiagnosed, and chemically restrained with opioids and antipsychotics, including "Black Box" drugs, sometimes for facility convenience, easy care and to diminish the veracity of an elder's voice. Access to medical records is vital and yet facilities regularly obstruct elder and family access. Many people "look the other way" including those entities funded by Medicare, while various professions and the pharmaceuticals benefit from the elder's plight. In 2015, Georgia passed a law which makes it a felony for groups of people to collude and racketeer to financially exploit an elder; that deterrent needs to be in effect at the Federal level and properly enforced. We need more oversight, better training, and improved staffing levels, especially in the night time. And we need to hold the owners of these facilities accountable. These changes need to be made at the Federal level and standardized nationwide. It is my hope that when you hear stories such as these, you see where the gaps in protections are, hold facilities accountable and correct the abuses.

STATEMENT SUBMITTED BY SUSAN EASTER

I would like to present my views for inclusion in the July 23, 2019 Committee on Finance hearing record on Nursing Homes Oversight. My name is Susan Easter. I am the power of attorney for my mother that lives in a nursing home in Oklahoma. It is both a skilled nursing facility and long-term care facility.

Other things Medicare charges is for wound products. Medicare does not make the facility apply the date to each wound product charged to Medicare so it is often over charged with no accountability. The products given can be wrong for her skin type. Wound products are kept in bulk in a wound cart.

My mother has things charged to Medicare from this nursing facility. It is not billed under the same company name to Medicare.

The Administrator has forged my mother's name before on a Notice of Medicare NonCoverage skilled nursing stay at this nursing home. The Administrator never got in trouble for this from Medicare because the Administrator never documented she did this.

My mother had a fall that was never investigated in 2016 where there was a hospital emergency room visit. After many months finally the Administrator told me it was CNA's/CMA's employees fault and the fall could have been prevented that caused 22 stitches to my mother's head. The CNA and CMA was never turned in to the Nurse Aid Registry for this very bad fall from this skilled/ltc nursing facility.

Medicaid did not show this nursing facility ever participated in customer satisfaction surveys until this year.

When Medicare allowed this nursing facility to rate themselves, they gave themselves five stars. I think that was in 2014 or 2015. The fall in 2014 was due to the owner having different heights on their flooring. It was never investigated or pointed out in nursing notes. My mother was a walk to dine and the CNA could have prevented the fall.

In 2015, my mother had another fall caused by a CNA. The Nurse said she could not let me see the incident report but she clearly explained the cause of the fall was due to errors of the Certified Nurse Aide. If you look at the Nursing Progress Notes, the fall is never documented, and the Physical therapist and Occupational therapist in skilled nursing did not document it either both in the same facility.

In 2017, my mother's charge nurse put her hearing aid in his pocket and it was never returned to the facility cart. The Administrator never did an investigation, and the Administrator never replaced the hearing aid. The Assistant Director of Nursing was the Charge Nurse on the day my mother got her hearing aid and should have placed it on the inventory list. It was also on the T.A.R. State Surveyors never asked the Nurse that lost the hearing aid if he documented it which it was never documented the Nurse lost it.

It would be helpful if in each state the State Department of Health would do nursing facility inspections every 3 months instead of yearly and review every fall instead of one or two resident's fall records what could be done to prevent the falls? In the facility my mother lives in many equipment errors were known but not repaired by the Administrator. Falls happened but not properly investigated by the Administrator. Have what really happened in a fall documented in Nursing Progress documented by the Charge Nurse on the shift it happened. In the skilled and long term care nursing home my mother, false reporting to Medicare in MOS reports, so Medicare is not being given the correct information that way either. The State Department of Health never catches it.

Wounds could have been prevented at this facility, but it is not documented how wounds could have been prevented. My mother has had wounds that could have been prevented. I would be happy to testify about what the facility could have prevented that ended up in hospital visits.

Hospitals could put a special code if the resident coming from a nursing home so that Medicare could track the falls and wounds.

My mother has had a surveillance camera in her nursing home room. In January it was unplugged without permission. The surveillance camera has had the memory card taken, the surveillance camera has been unplugged, the surveillance camera has been blocked by putting something in front of it, it has been damaged. For example the camera showed a nursing home employee taking a picture of my mother while she was in bed on his shift. He had seen blood from a wound that never got reported on his shift or the previous shift by that charge nurse is when the open wound actually happened from an error of the Certified Nursing Aid that sliced my mother's leg that caused a large wound on the bed rail but the CNA never reported it. The Administrator's daughter in December looked like she had taken a picture of my mother, but the Administrator refused to provide a cell phone policy in a records request.

In January, through errors of the nursing home, my mother ended up with a broken arm. My mother was sent to an emergency room as she had told me there was only one CNA instead of two helping her with the Sit to Stand and that the Sit to Stand legs were still broken. The legs not working on the Sit to Stand can cause the resident to have to extend their arms stretched out abnormally. The administrator had not had the Sit to Stand legs fixed or a new Sit to Stand ordered and I brought up in a care meeting in January but it was never documented by the Administrator. It was not documented by the Director of Nursing, no charge nurse, and no S.S.D. Also in the month of January a hospitality aide caused a injury to my mother. Neither of these were documented in the January end of month resident nursing January summary in the resident's Nursing Progress Notes.

It would also be excellent if Medicare could have nursing homes require a scanning system like many companies do where employees badge in and out so there is accuracy of each employee that is actually in the building working including the Administrator. When my mother was in skilled nursing, due to low staffing and lack of accountability, my mother had to be rushed to the hospital from their errors and it was not documented accurately in the MDS Medicare report. Medicare does not require that nursing homes send in the Notice of Medicare Non Coverage to Medicare when skilled nursing is over. Medicare can get charged thousands of dollars extra when skilled care was being charged to Medicare because Medicare does not have each skilled care itemized with the dates on when each skilled care was going on in the billing itemization from the nursing home. The Administrator has forged my mother's name to the Notice of Medicare Non Coverage, and my mother was never told and I was never told as her power of attorney about the Notice of Medi-

care Non Coverage and there was no meeting to prove it. The skilled meeting did not exist. The most recent skilled visit with my mother, there was not even one nursing meeting talking about nursing. It was not allowed. There was a very bad wound that should have been prevented.

The Finance committee needs to crack down on Nursing Homes that send the resident to the hospital from the mistakes and errors of the nursing home in the United States.

The Administrator's daughter documented she was caring for my mother as a Certified Nursing Aide in documentation, while my mother was never there as she was in the hospital so that would be false documentation. State Surveyors never wrote her up for false documentation.

I will be happy to testify before the U.S. Senate Finance Committee in future Nursing Home Neglect and Abuse and Oversight meetings.

LETTER SUBMITTED BY SUSAN INGLIS, R.N.

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My mother Patricia D. Inglis is currently living at Fair Haven Long-Term Care Facility in Birmingham, Alabama since March 2018. The directors and managers believe that 1–3 CNAs (certified nursing assistants) on days and evening shifts are enough to take care of 22 dementia and severe mobility issue residents for baths, meals, and diaper changes. I know for a fact my mother never gets her teeth cleaned and she sits in her wheelchair for about 12–14 hours a day. There are few activities, many of the residents have severe arthritis and osteoporosis and are bent over ALL DAY! Some of the residents need help with eating and drinking with minimal or little assistance.

Two weeks ago my mother (dementia and osteoporosis) had an abuse grievance written by an LPN on duty about a CNA who was rough with my mother placing her in bed and her neck was hurt. My mother informed me that the CNA cursed at her and she hit her head against the wall. I followed up with the state about the report and was told since my mom had dementia that the report was inaccurate and only a CNA and my mother were in the room alone. My question is how do I protect my mother since no camera or voice recordings are allowed in the State of Alabama. My mother was unable to lay her head/neck in her wheelchair until a week later.

I reported alone to the Alabama State of Public Health in March 2019 about the norovirus outbreak at Fair Haven in which more that half the residents had the virus including me and my mother. The State investigated the incident and I read the report which was a lie. A daughter whose parents live there showed me the empty specimen cups from their room. When Fair Haven was investigated they had 5 CNAs, a cleanup specialist, and the tables were clean with disinfectant/placemats were washed. Now the tables are being wiped with just water, dirty washcloths/placemats are not being washed.

I have come to the conclusion that the nursing home industry along with the lobbyists have so much power there is little a family member may do to protect them. Fair Haven costs $9,000/month. My fear for my mother is that she will run out of money and the lack of decent care is horrific.

Please as a governing body protect the elderly/disabled who are vulnerable and cannot speak for themselves. Unfortunately a large amount of the American population are gong to end up in a nursing home. Let us try to ensure decent care and activities.

Sincerely,

Susan Inglis, R.N.

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Mr. Chairman and Mr. Ranking Member, LeadingAge appreciates the opportunity to submit this statement for the record of the Senate Finance Committee hearing, *Promoting Elder Justice: A Call for Reform.*

The mission of LeadingAge is to be the trusted voice for aging. Our 6,000+ members and partners include nonprofit organizations representing the entire field of aging services (including 2,000 nursing homes), 38 state associations, hundreds of businesses, consumer groups, foundations and research centers. LeadingAge is also a part of the Global Ageing Network, whose membership spans 50 countries. LeadingAge is a 50l(c)(3) tax-exempt charitable organization focused on education, advocacy and applied research.

Mistreatment of vulnerable elders can never be tolerated in any setting. Preventing elder abuse is something that LeadingAge and its members have fought for over many years. In the 1980s, we supported and promoted "Untie the Elderly," a first of its kind campaign aimed at providing alternatives to tying nursing home residents down, a practice that now has all but ended. We also have partnered with the Center for Advocacy for the Rights and Interests of the Elderly to distribute a staff training program for abuse prevention in nursing homes. Our members work every day to identify, address, and prevent elder abuse, whether in our congregate settings or the wider community.

Current federal law severely and appropriately punishes incidents of abuse committed in nursing homes. The Elder Justice Act provisions of the Affordable Care Act, which LeadingAge strongly supported, specify that nursing homes and their employees must report any reasonable suspicion of a crime committed against a resident to both local law enforcement and the state survey agency within specific timeframes. The law provides severe penalties for failure to comply with these reporting requirements. LeadingAge and its state partner organizations have provided extensive resources and education to our member nursing homes on preventing abuse and complying with reporting requirements.

The Nursing Home Reform Act incorporated into the Omnibus Budget Reconciliation Act of 1987 (OBRA '87) provides for penalties against both individual perpetrators of abuse against nursing home residents and against nursing homes where abuse occurs. In addition to the reporting requirements of the Elder Justice Act, OBRA regulations provide for both annual and complaint-based surveys of nursing homes that may be triggered by incident s of abuse or uncover ongoing abusive practices. The Centers for Medicare and Medicaid Services (CMS) and state agencies have responsibility for enforcing these provisions of OBRA '87. Recent Government Accountability Office reports have investigated the effectiveness of federal and state enforcement and have made recommendations to CMS for improvements.

LeadingAge member nursing homes go beyond regulatory requirements to provide the highest quality care for residents. For example, Safe Care for Seniors, a program spearheaded by LeadingAge Minnesota, is designed to eliminate preventable harm in the course of caregiving. Through both words and actions—and with the senior at the center of all they do—providers renew their commitment to give safe, quality care to ensure a high quality of life for those they serve. Providers, team members, residents, and families partner together to promote a culture of safety that allows residents to thrive in a community built on safety, trust, dignity, and respect. Providers and individuals take a two-fold pledge to increase the safety of the people they serve. They promise to always treat the people for whom they care with respect and dignity, to take steps to get to know them as individuals, and to speak up if they see something that may be unsafe or makes them feel uncomfortable.

Gayle Kvenvold, President and CEO of LeadingAge Minnesota put it this way: ". . . we began by asking this question: *what is in our power to do to bring about the best lives for our elders?* And that led us to renew our commitment to the heart and soul of our work—respect, safety and dignity for those we serve—and to commit as a statewide caregiving community and as LeadingAge Minnesota to some of the most meaningful work we will ever do. This is our calling, our commitment and our culture. Together we will prevent harm before it occurs and create a culture of safety. Together we will help those whose lives we touch, live their best lives." As the na-

tional partner of LeadingAge Minnesota, LeadingAge is building on and promoting the positive results of this initiative to our members in other states.

Any abuse of nursing home residents is intolerable and inexcusable. Existing laws and regulations provide mechanisms to detect, punish, and, to the extent possible, prevent these kinds of incidents in residential settings.

The same cannot be said for protection of elders living in community-based settings. Elder abuse is one of the least reported, investigated, and addressed forms of violence against elders. The Department of Justice estimates that one in ten older Americans are victims of physical, emotional and/or financial abuse. According to statistics collected by the National Council on Aging, in approximately 60% of reported instances, abuse of an elder has been perpetrated by a family member, most often a spouse or adult child. Elders living in the community may be vulnerable to abuse due to dementia and other physical or mental disabilities. They often are isolated from social networks or other resources to turn to for help. And they frequently are dependent on the perpetrators of abuse for shelter and day-to-day support.

LeadingAge members see the impact of abuse every day. Financial and material exploitation and physical and emotional abuse deprive elders of their dignity and security and can lead to poverty, hunger, homelessness, poor health and wellness and even premature death. LeadingAge members have been in the forefront of aging services providers in attacking this scourge. Our members work with federal, state and local authorities to identify and serve older persons who are victims of abuse. LeadingAge members created the first shelters for older victims of abuse, providing comprehensive shelter for victims of elder abuse, and legal, social, and care management services.

In recent years, we have been at the forefront of developing and supporting measures to prevent abuse and protect older people who have been abused. Examples include:

- Participating in global discussions about elder abuse and human rights through our collaboration with the Global Ageing Network (formerly the International Association for Homes and Services for the Ageing (IAHSA));
- Working with the Consumer Financial Protection Bureau to develop and distribute educational materials and tools for providers to recognize, prevent, and respond to financial abuse of older people in affordable housing;
- Partnering with district attorneys, law enforcement agencies, financial institutions, social service agencies, and businesses that come in contact daily with seniors to help them recognize signs of physical and financial abuse; and
- Supporting members who are opening abuse shelters using nursing homes as temporary refuges for physically, emotionally, and financially abused older people in the community.

An example of long-term care providers as a resource for elders in abusive situations is the Hebrew Home at Riverdale, a LeadingAge member nursing home in the New York City metropolitan area. The Hebrew Home has served low-income elders of all faiths for over a century; currently 18,000 older New Yorkers receive services at or through the Hebrew Home.

Since 2005, the Hebrew Home has operated the Harry and Jeanette Weinberg Center for Elder Justice. The Center pioneered the provision of safe shelter for older people living in the community who are experiencing abuse. The Center initiated the SPRiNG (Shelter Partners: Regional. National. Global.) Alliance to replicate its flexible shelter model in communities throughout the United States and around the world.

Daniel Reingold, President and CEO of the Hebrew Home, has worked with the Elder Justice Coordinating Council, established under the Elder Justice Act to better integrate federal, state, and local responses to elder abuse situations. He notes that the Hebrew Home now screens new residents for signs of past abuse, with services available from the Weinberg Center to care for elders who have experienced it. Of the 536 rehabilitation patients the Hebrew Home screened from May 2017 through May 2018, 63 individuals or 12% of the total showed signs of having experienced abuse before coming to the nursing home. For over a decade, the Hebrew Home has provided the trauma-informed care older people need to heal from past abuse.

In addition to providing temporary shelter to victims of elder abuse, who generally cannot be accommodated in traditional domestic violence shelters, the Weinberg

Center collaborates with the District Attorneys of the Bronx, New York City, and Westchester County to train law enforcement, social services, and judicial officials in recognizing and dealing with elder abuse. The Center's outreach program provides resource information in shopping centers, retirement communities, senior centers, and other areas where at-risk seniors may find it. The Center has replicated its program at 15 other organizations throughout the United States and continues working to expand this shelter movement for older adults.

Abusive situations involving elders and their family caregivers can develop for a number of reasons. Caring for a dependent elder can be emotionally rewarding; it can also be physically, financially, and emotionally draining. A *Health Affairs* blog, *A Study of Family Caregiver Burden and the Imperative of Practice Change to Address Family Caregivers' Unmet Needs,* points to the "well-documented" physical and emotional toll caregiving imposes on family members caring for someone with dementia and the lack of support family caregivers receive. The article argues that addressing the needs of caregivers improves not only their situation and that of the family member for whom they are caring, but also can help to lower health care costs.

The article notes the kinds of behaviors family caregivers find most challenging—aggression and agitation, repetitive actions, incontinence, wandering, and refusal to eat, take medicine, or bathe. In nursing homes, care staff are trained in best practices to deal with these situations, and staff get respite from them when their shifts end. Family caregivers, according to the findings in the article, do not have the same level of knowledge of their loved one's disease progression or how challenging behaviors can be dealt with successfully. And family members do not get respite from the ongoing, day-to-day caregiving burden.

The article recommends interventions to better support family caregivers. Several federal programs under the Older Americans Act (OAA) provide the kinds of services family member s need to avoid the kind of burnout that can lead to abuse of a dependent elder. Adult day services, Lifespan Respite Care, and Family Caregiver Support are the kinds of services essential to enable families to continue caring for loved ones with chronic physical and/or mental disabilities.

The Older Americans Act is due for reauthorization and it is chronically underfunded. LeadingAge urges Congress to reauthorize these programs and provide the resources needed to ensure that services will be available to family caregivers when they are needed.

The Geriatric Workforce Enhancement Program under Title VII of the Public Health Act includes education for family caregivers on managing the challenges posed by Alzheimer's Disease and other dementias. This program also is due for reauthorization and also needs increased funding.

Conclusion

Abuse of nursing home residents must be effectively detected, punished, and prevented. LeadingAge will continue working with policymakers, consumers, researchers, and families to ensure that all nursing homes are safe places for people who need long-term care. We will build on our members ' initiatives that have made nursing homes a resource and safe haven for older people who have experienced abuse in the community.

It is difficult to accept that most abuse of elders happens not at the hand of strangers or nursing home staff, but from the family members on whom an elder frequently must depend. But unless this reality is recognized and dealt with, elder abuse will continue unchecked.

The Elder Justice Act established a framework for integrating initiatives at all levels of government to detect and deter elder abuse. Existing federal programs can help to prevent elder abuse by giving family caregivers the skills and resources they need to avoid burnout that can lead to abuse. LeadingAge urges this committee and Congress to support and enhance these measures to bring about real solutions that will ensure the safety and security of all older Americans.

LEADINGAGE MINNESOTA

August 2, 2019

U.S. Senate
Committee on Finance
Dirksen Senate Office Bldg.
Washington, DC 20510–6200

Mr. Chairman and Mr. Ranking Member, LeadingAge Minnesota appreciates the opportunity to submit this statement for the record of the Senate Finance Committee hearing, Promoting Elder Justice: A Call for Reform on July 23, 2019.

LeadingAge Minnesota is driven to transform and enhance the experience of aging. Working alongside our members, professional caregivers, advocates and consumers, we are collectively shaping the future of long-term services and supports to ensure seniors in Minnesota live with dignity, meaning and purpose as they age. Together with 70,000 professional caregivers, our more than 1,000 members provide quality, compassionate care, services and support to 70,000 seniors every day in independent senior housing, assisted living communities, in-home care, adult day services and skilled nursing facilities.

We assure you that you can and should continue to be proud of the care provided to seniors throughout Minnesota. AARP and the SCAN Foundation has consistently ranked Minnesota as one of the top states in the nation for the quality of senior care and the options we provide. But we know that there is more work that needs to be done to best prepare Minnesota for the evolving needs of its rapidly growing aging population. As providers, we welcome and embrace the opportunity to ensure our care delivery system is prepared to meet the needs of seniors today and in the future.

It is in our power, as providers and professional caregivers, to enable the seniors we serve to live their best lives. Maltreatment in any form strikes at the very heart—at the very core—of what we do. We own the responsibility to look upstream of any tragedy to better understand its root causes and to consider the impact on residents and their families whose trust and confidence may be in doubt. We are accountable for the culture in our organizations and must continually assess our systems and processes to ensure we have skilled, compassionate caregivers who are providing high quality care and are supported and empowered to respond appropriately in difficult situations. Most of all, we are committed to preventing potential harm before it occurs.

The reports released by the United States Government Accountability Office (GAO) and the Office of the Inspector General (OIG) raise key concerns that must be addressed to protect older adults from abuse. We share these concerns and support the recommendations presented in the reports.

The GAO Report, *Nursing Homes: Improved Oversight Needed to Better Protect Residents from Abuse,* provides key data and insight on the trends and types of abuse occurring in nursing homes in recent years, the risk factors for abuse and challenges facing CMS and other stakeholder agencies in investigating abuse, and CMS oversight intended to ensure that nursing home residents are free from abuse. The report highlighted areas of improvement that we also support, including the need for improved reporting, data collection and analysis, transparency of that data, and the need to reduce the gaps that can exist in the investigations and enforcement process.

But even as these recommendations will be helpful in improving reporting, streamlining enforcement and responding to maltreatment after it happens, additional policy changes must be explored to facilitate the prevention of maltreatment before it occurs.

In Minnesota, we have acted in many of the areas recommended by both the OIG and GAO reports. In the past few years, the Minnesota Legislature and state regulatory agencies have strengthened laws around background checks, reporting, data collection, and consumer protection in long-term services and supports. Despite these steps forward in our state, we continue to see a high number of unsubstantiated and substantiated maltreatment reports in long-term services and support settings.

Consider the following:

- Caregivers are the backbone of quality care, but it has become increasingly more difficult to recruit and retain professional caregivers. It is projected that

Minnesota will need 25,000 additional professional caregivers over the next decade. Yet, we struggle to fill the open positions we have today. In 2018, Minnesota experienced a net loss of 1,231 nursing assistants and on any given day in our state you will find more than 3,000 open nursing assistant positions. The unfortunate reality providers struggle with every day is that fewer and fewer individuals seek out this work. If we are to tackle the maltreatment epidemic, policymakers and providers must partner to find better ways to elevate this profession to attract and retain the best and brightest to the field.

- While a necessity in the field of long-term services and supports, background checks are not always a dependable way to weed out potential employees who would place older adults in vulnerable situations where they could be subjected to harm. Minnesota has adopted a thorough background check system, but it is not without its challenges—from failing to provide timely accurate information to access issues where potential employees in rural areas of the state cannot easily access a background check location. Policymakers should look at ways to improve this system.
- Reporting is one of the most critical elements in the foundation of vulnerable adult protection. In Minnesota, long-term services and support providers are required to self-report any potential suspected cases of maltreatment immediately and then take immediate steps to investigate and remedy the situation. This system is also in need of improvement as the response time for regulatory and law enforcement investigators is not immediate. In some cases, perpetrators of abuse may have terminated employment before a formal finding is reached. As those perpetrators are rarely flagged in a background check, they have the opportunity to again work in another long-term services and support setting and continue to pose a risk to the seniors they serve. This requires attention at both the state and federal level as, at this time, there is no reliable way to prevent this scenario from happening.

During the 2019 legislative session, LeadingAge Minnesota was proud to work in collaboration with lawmakers, regulators and consumer advocates to pass the landmark Elder Care and Vulnerable Adult Protection Act of 2019. This Act will strengthen regulatory oversight and consumer protection, as well as provide greater clarity and transparency for consumers and their families. Elements of this legislation include licensure of assisted living settings, licensed credential for leaders in those settings, electronic monitoring in all long-term services and support settings, enhanced dementia care standards, more transparency in contracts and appeal rights and increased and immediate fines for the most egregious acts of harm.

We recognize and support the need for enhanced regulation, reporting and enforcement of negligent behavior and purposeful intent that results in harm to the older adults we serve. But this is only one frame in the much larger picture of vulnerable adult protection. We strongly believe an equal priority must be placed on preventing harm *before* it occurs.

Recognizing that improvements to a regulatory framework are not enough to protect seniors from harm, LeadingAge Minnesota launched a comprehensive safety and quality improvement program to proactively address the intentional and unintentional harm that can occur in the course of caregiving. Safe Care for Seniors provides the structure and support to create and strengthen safe, inclusive and trusted environments that empower quality, partnership, communication, learning and improvement.

Safe Care for Seniors is being led across Minnesota by dedicated, compassionate providers and professional caregivers who are united in their mission to enhance the lives of all who live and work in their settings. It begins with a pledge to keep those we serve safe from harm and provide care with respect and dignity—always. It is then followed by a five-step action plan:

- Improving the partnership between residents and families, leaders, managers and direct line staff.
- Encouraging and empowering staff, residents and families to speak up if they see something unsafe or makes them feel uncomfortable and ensuring systems and supports are in place to appropriately respond to those concerns.
- Uncovering new opportunities for learning and improvement based on reports and data.
- Strengthening the leadership commitment to safe, quality care, including the appointment of designated safety champions in each setting.
- Creating a Just Culture that supports reporting, learning and improvement.

Since the program launched in February 2019, more than 440 organizations have taken the Safe Care for Seniors Pledge and committed to the five-step action plan. In addition, more than 25,000 caregivers, residents and volunteers have demonstrated their commitment to respect, safety and dignity by taking the Safe Care for Seniors pledge.

CONCLUSION

Elder abuse is an important public health issue as our nation's senior population now exceeds the growth rate of the population of the national as a whole. As our aging population experiences rapid growth, we are seeing a growing gap in the number of professional caregivers as well as inadequate reimbursement models in Medicare and Medicaid to support to evolving and diverse needs of our aging population.

No one person, organization or regulatory agency has the solution that will ensure older adults live in safe, secure environments that support dignity, choice and quality as they age. Even with the proactive, preventative focus led by providers and the increased regulatory oversight measures by the state and federal government, we must come together and take a productive look at the quality of care, services and support from all sides—prevention, regulations, workforce and funding. It's going to take a lot of us—providers, regulators, lawmakers, consumer advocate, older adults and their families—working together to advance a resident safety movement that is just, fair and ensures a high quality of life for all who live and work in long-term services and support settings.

We call upon you to embrace the unique positioning you have to convene an initiative around the much broader solution that is needed to ensure a high quality of life for Americans as they age. You have the power to bring people together on our mutually shared mission to keep seniors safe from harm, and we welcome the opportunity to collaborate and embrace the work that will define and implement real solutions to ensure the safety and security of older Americans—today and in the future.

Thank you for your leadership and commitment on behalf of older adults.

Gayle Kvenvold
President and CEO

STATEMENT SUBMITTED BY DEAN ALAN LERNER

This statement is submitted by Dean A. Lerner as an individual with nearly two (2) decades of hands-on experience on the subject matter of Elder Justice. By way of background, I am a 1974 Graduate of Grinnell College and a 1981 Graduate of Drake University Law School. I am an AV rated attorney in the State of Iowa, admitted to our state and federal courts. I served for sixteen (16) years as an Iowa Assistant Attorney General, three (3) years as Iowa's Chief Deputy Secretary of State, and nearly ten (10) years as Iowa's Deputy/Director of my state's Department of Inspections & Appeals (DIA) (the state agency responsible for federal and state oversight of nursing homes, assisted living programs, and other health care facilities, among other statutory responsibilities).

After these full-time positions, totaling nearly thirty (30) years of Iowa public service, I served for several years as a part-time contractor/consultant to the Centers for Medicare and Medicaid Services (CMS), retained to advise the Director of the Division of Nursing Homes regarding enforcement of federal nursing home laws and regulations. In this capacity, among other responsibilities, I served as an instructor to State Survey Agency Directors to educate them in fulfilling their contractual survey responsibilities. I also served in a part-time contractor/consultant capacity to the United States Attorney for the Northern District of Iowa, designated to be the District's Health Care Fraud Consultant. In this capacity, [assisted in prosecuting Iowa's first Federal False Claims Act case against a nursing home responsible for resident harms attributable to grossly substandard care. I also participated in the Northern District's Task Force work pursuant to its designation by DOJ as one often (10) Districts in the nation to focus on elder financial abuse and nursing home failure of care cases.These efforts represent only some of my work in the area of Elder Justice. I would be honored to share further thoughts and opinions with the Committee, based upon my years of experience and substantive expertise.

Having heard the testimony of witnesses, and having read Statements of and to the Committee, I offer the following. Nothing stated herein is meant to criticize all nursing homes, many of which are providing the quality of care every resident deserves.

Nonetheless, serious caregiving and oversight problems exist, the solution of which would promote Elder Justice.

1. Follow the money. Although not surprising, it seems incredible that the nursing home industry has been able to convince Congress, without any examination of this claim, that its margin of profit is only one-half of one percent (as asserted during the Hearing). The profitability of this industry needs to be carefully examined, and the truth of this matter exposed. The Committee might begin this inquiry by calling self-proclaimed philanthropist David Rubenstein, inquiring how much he profited from his Carlyle Group's investment in this industry. The Committee might also be interested in researching issues with respect to corporate regulatory compliance during this period of time, in the interest of Elder Justice.

Most of the Country's nursing homes are for-profit, and available studies demonstrate that quality of care is correlated to the profit motive. If profits are razor thin, why are there so many investor groups continuing to be involved in nursing home operations? The nursing home industry is masterful when it comes to creative accounting. Profits are hidden among ownership/lease holds of real estate, payments to related/unrelated management companies, the ownership/operation of the facility itself, etc. A team of accountants and attorneys should be engaged to unwind purposefully complex accounting/legal schemes and to expose the industry's false claims about minimal profits. Nursing home Cost Reports should be restructured to reveal, rather than to conceal, this information. In any event, the Committee needs to ascertain the truth. The reality, as will become readily apparent, is that vast sums of taxpayer dollars are being directed to profits, as opposed to caregiving. If the Committee's concern is Elder Justice, following the money is an essential, initial determination.

One clear and easy item for the Committee's consideration is whether Governor. Mark Parkinson should be making, annually, many millions of dollars as President and CEO of the American Health Care Association (AHCA), with annual revenues in the tens of millions of dollars. More important is the question where his salary and benefits, and the funds for the extensive AHCA lobbying operations come from. Is the AHCA's lobbying power, announced as a major priority by Mr. Parkinson upon his 2011 appointment, derived from government taxpayer dollars? This is another important area for the Committee's investigation when following the money. My understanding, at least in Iowa, is that Association Dues are allowed to be reimbursed to facilities by Medicaid through facility Cost Reports, and passed through to the Associations. In Iowa, the Iowa Health Care Association (IHCA), as reflected on its Form 990 non-profit tax return, garners millions of Medicaid dollars for its operations. I suspect that AHCA is funded in much the same way. This is just plain wrong, and Elder Justice demands otherwise. Excessive profits and Association Dues should be dedicated, instead, to direct caregiving by staff, which brings me to the next item for the Committee's consideration, staffing.

2. Staffing. While working as a contractor/consultant to the CMS Director of the Division of Nursing Homes, my impression was that although staff numbers and qualifications and training, from RNs to LPNs to CNAs, etc., were recognized as the single most important factors to providing proper care, care required by law and regulation, CMS would only nibble around the edges of addressing this recognized, critical problem. The expense factor (the resistance of industry) effectively made these critical factors, mandatory training and mandated hours, essentially "off limits" to CMS. When the Committee is prepared to analyze where taxpayer dollars are actually spent (see #1 above), a redistribution of resources can begin to effectively address the most important factors in Elder Justice: *trained, mandated, staff caregiving.* Mr. Parkinson's testimony that mandated staffing requirements will not fix the problem is misdirection. Ask any resident at any nursing home throughout the Country whether there are enough staff to meet the care needs of residents, and the near-unanimous answer will be "no," or "hell no." Ask them about staffing levels during nights and weekends, and their answers will likely be even more emphatic negatives. When addressing Elder Justice, the Committee might question whether nights and weekends are truly different from weekdays—are already insufficient staffing levels justifiably minimized? When do abuse and neglect occur?

The Committee may wish to compare Mr. Parkinson's "elaboration" regarding AHCA's claimed success in staffing (bullet point three on page two of his Testimony) with the recent Harvard/Vanderbilt research revealing that 75% of over 15,000 nursing homes studied were almost never in compliance with federal expectations for staffing, given the residents' particular acuity levels.

Ask any staff member who is able to respond (without fear of retribution) whether they have been trained properly, and whether they have enough time to properly care for residents. The answers will be identical.

Ask any staff member who has been called upon to toilet a resident whether they were instructed how they can safely leave that resident when a call light/emergency presents. Ask them if they were blamed when a resident was harmed, when management/ownership was the actual responsible party for staff shortages. In Iowa, the time allowed to respond to a call light is fifteen (15) minutes. The Committee might wish to consider their loved one waiting this amount of time for assistance, assuming this time delay is even regularly adhered to.

Another concern the Committee might be interested in is the industry's utilization of contract staffing, instead of consistent staff, staff who actually know and love their customarily assigned residents.

If this Committee is truly interested in Elder Justice, these are some of the inquiries that should instruct its immediate action. And, the Committee might consider meeting with actual caregivers and residents, privately.

3. Regulatory compliance. There are two (2) fundamental elements to regulatory compliance. The first is embodied in the regulations themselves: what areas do they address and how timely is their implementation. Although CMS, several years ago, after much study and effort, developed and commenced a three-year schedule implementing these new regulations, they have been weakened, revised/eliminated, and delayed. Elder Justice is not being served by CMS' rulemaking "adjustments." The Committee is now holding hearings and soliciting Statements on issues that have been researched, reported on, and yet unaddressed for decades, ever since the passage of OBRA '87, the Nursing Home Reform Law. GAO and OIG studies have found Elder Justice concerns regarding unimaginable, preventable harms to residents. One might think it advisable for this Committee to gather these myriad Reports and recommendations and read and consider them. Too, the Committee may wish to study the Comments submitted regarding the regulations, as the regulations were being developed. These Comments, part of the rulemaking process, provide a wealth of information.

It is time that Congress take the side of residents and Elder Justice, rather than acceding to the weakening and delays sought/demanded by industry. Reductions of "regulatory burdens," as characterized by industry, are costing seniors their lives. The second element to regulatory compliance is the actual enforcement of the regulations. Industry clout and political interference with CMS and State Survey Agencies has been the subject of at least one OIG Report. When State Survey Agencies are not allowed to do their jobs, Elder Justice suffers and residents are harmed. When I held Office, I proposed legislation that prohibited interference in the Survey process, by anyone. A poor performing facility subject to DIA oversight was visited by three state legislators, during which time campaign fundraising was conducted. Soon thereafter, I was contacted and asked to "explain" the Department's actions. My response was to inform *The Des Moines Register* of this obvious attempt to interfere with the Survey process.

The Committee may wish to consider whistleblower legislation, in addition to passing specific legislation that prohibits interference with enforcement. Of course, adequate funding for State Survey Agencies to enforce the regulations is another crucial element to obtaining Elder Justice. If, for whatever reason, states refuse to contribute their required state share to receive their federal "match," Surveys suffer.

Additionally, state Surveyors are often not paid as well as industry pays. The outcome is obvious. And, it is common knowledge among regulators that Surveyors need at least a year's time to effectively fulfill their Survey oversight responsibilities. It would take more than my allowed ten (10)

pages to inform the Committee about interference/inhibitions to surveying for regulatory compliance.

4. Direct Care Workers. When considering changes, Elder Justice suggests that the Committee recognize the underpayment, scapegoating, and horrific demands placed upon direct care workers. In Iowa, during the period of time I held Office, the turnover rate for CNA's was around sixty-five percent (65%). This workforce wasn't paid a living wage, often lacked health insurance, and often lacked necessary basic training to understand and care for the residents in their charge. I assisted in the drafting of CMS' training manual, *Hand in Hand,* a resource manual (with accompanying videos) provided to nursing homes throughout the Country. The Committee may wish to determine whether staff are required to complete this training, or whether it remains voluntary, or even remains available. There will never be Elder Justice without major improvements directly impacting this workforce responsible for the health, safety and welfare of some of the most vulnerable among us.

5. Pre-dispute binding arbitration. On July 29, 2019, *The Des Moines Register* printed my Guest Editorial on pre-dispute binding arbitration, titled *"Grassley has an opportunity to demonstrate his true commitment to Iowa seniors."* Because my editorial addresses this issue head-on, it is copied here, verbatim: The *Register's* July 3 editorial, *"How Grassley can help protect seniors,"* discussed a federal regulation that should be of great interest to everyone concerned about rolling back senior-industry regulations that protect the most vulnerable among us. Less than two weeks after the editorial was published, the Trump administration issued its final rule permitting nursing homes that voluntarily participate in the Medicare/Medicaid programs to have prospective residents sign pre-dispute binding arbitration agreements. This reverses the Obama administration's rule that forbade such agreements.

Why should we care? Signing these agreements means that residents (and family members) give up their right to go to court over everything, including neglect, abuse, not getting medication, being given the wrong medication, and being stolen from. Binding arbitration is their only recourse, and there is no appeal from the arbitrators' decision. Although the Trump administration apparently recognized the draconian effect of nursing homes requiring seniors needing care to agree to pre-dispute binding arbitration agreements, the administration's final rule still permits their use.

Grassley has an opportunity to demonstrate his true commitment to protecting seniors. Changing the law to prohibit nursing homes from allowing prospective residents to give up their right to sue would "trump" the administration's final rule. The senator told the editorial board "it's worth Congress having more information on how agreements are used, and there are 'pros and cons' to arbitration." (This statement should remind us of another absurd remark: ". . . there are very fine people on both sides.") He cited the costs of lawsuits on nursing home care, and asked whether "that increased cost just mean(s) more money in lawyers' pockets, instead of victims?"

Let's shed some light on those concerns. First, this issue is one that has been before the Congress for many years, so there's plenty of information already available on how these agreements are used. This includes a 2017 letter to the Centers for Medicare and Medicaid Services signed by 31 senators and a 2015 letter signed by 34 senators, which states: "Forced arbitration clauses in nursing home agreements stack the deck against residents and their families who face a wide range of potential harms, including physical abuse and neglect, sexual assault, and even wrongful death at the hands of those working in and managing long-term care facilities. These clauses prevent many of our country's most vulnerable individuals from seeking justice in a court of law, and instead funnel all types of legal claims, no matter how egregious, into a privatized dispute resolution system that is often biased toward the nursing home. As a result, victims and their families are frequently denied any accountability for clear instances of wrongdoing."

Second, Grassley's comments contain an inherent mistrust of American juris prudence, and a misunderstanding of lawsuits brought by seniors. Nursing homes purchase insurance policies to retain lawyers to defend

their actions. The lawyers representing injured people take cases on a contingency basis and only recover money if the nursing home is found liable by citizen juries. Let's be honest, senator. You don't require any more information. You are familiar with this issue. Further, when industry attorney Kendall Watkins came to your defense with his July 12th op-ed, *"Arbitration is an affordable legal resource for seniors,"* he, like you, neglected to mention critical facts.

The damage caused to residents by mandatory and voluntary pre-dispute binding arbitration agreements is real. In a typical agreement, every aspect of each residents' life is subject to arbitration. Arbitration stifles/prohibits obtaining information from nursing home defendants that would otherwise be available to residents, as plaintiffs, through the rules of discovery in a court of law. Moreover, unlike a court proceeding, arbitration does not occur in a public forum, so the nursing homes' actions/abuses are not exposed to the public.

Keeping nursing home abuses from the public does not serve the public interest. Researchers from Harvard and Vanderbilt medical schools examined records from 15,399 nursing homes covering April 2017 through March 2018. The study found that 75% of skilled nursing facilities were almost never in compliance with federal expectations for staffing, given the residents' particular acuity levels. Countless studies and even federal Office of Inspector General findings over many decades point to serious health, safety and welfare issues in nursing homes. Most of Iowa's nursing homes are for profit, and unfortunate care correlations have been associated with the profit motive. The harms caused by these never-ending serious problems are all too prevalent, and their redress deserves more than arbitration.

It is well past time for your commitment, Senator Grassley. Iowa's seniors are waiting.

6. Clarification of the definition of abuse and neglect. AHCA's faulting an "unclear" definition of abuse and neglect for the June 2019 OIG findings, "Incidents of Potential Abuse and Neglect at Skilled Nursing Facilities Were Not Always Reported and Investigated," is ludicrous. See pages 4–5 of Governor. Parkinson's Testimony. This assertion, alone, should demonstrate to the Committee that some nursing homes are actually looking for a reason not to report abuse and neglect. They do so in order to avoid oversight and investigation by State Survey Agencies and law enforcement into their culpability. They do so in order to avoid deficiencies, and in order to avoid Immediate Jeopardy determinations, and in order to avoid civil money penalties and other enforcement remedies. The rule for reporting, pure and simple, is: When in doubt, report. This is not too complex to understand. Further, state law definitions of abuse and neglect are also different from federal definitions. There will always be differences, this is not the cause of reporting failures.

Even if the Committee were to direct CMS to "clarify once and for all the definition of abuse and neglect and ensure that those same definitions and reporting standards are consistent across all health care settings," as "implored" by AHCA (pp. 4–5 of Governor Parkinson's Testimony), nursing homes will lawyer up to avoid reporting. Just like the reporting positions taken by the Iowa Health Care Association when I supervised the State Survey Agency, some facilities will do everything they can to avoid reporting. And, if the Committee were to decide to pursue a new definition, I predict the industry Associations will do everything they can to ensure that the chosen definition will limit their reporting responsibilities, and offer them an "out" for their reporting failures. I fought this fight over Iowa's definitions for reporting of abuse and neglect when I was the Director of DIA. We changed Iowa's law on dependent adult abuse, but the new statute was weakened to satisfy industry. Rather than alter definitions, a better solution to this issue is to severely sanction failures to report.

7. The States' Long Term Care Ombudsman Programs. A central function of the Long Term Care Ombudsman Program is to investigate and respond to resident concerns. Applying national standards, the Institute of Medicine (IOM) long ago established that nearly thirty (30) Ombudspersons were required to attend to Iowa's recipient population. Never even approaching this recommended minimum, the Iowa Long Term Care Ombudsman program has been decimated by staffing cuts (the last reported num-

ber was 8 remaining Ombudspersons), such that face to face visits are rarely, if ever, possible. The Iowa agency responsible for these important functions acknowledged that telephone conversations would be substituted for on-site visits. Suffice to say, this is an embarrassment to the State of Iowa and an affront to residents when they are not afforded fundamental entitlement to a viable Long Term Care Ombudsman Program. Elder Justice demands otherwise.

8. The Federal Special Focus Facility Program (SFFP). Only recently were all of the CMS nominated special focus facility names made public. There was no reason, ever, for these CMS identified poor performing facilities not to be know to prospective residents, and the general public. It is a wonderment why CMS chose to secret this information from the public, and the Committee may wish to inquire why this was the case. The Committee may wish to also inquire whether there are any other troubling facts about specific facilities that should be made public by CMS.

When I was Director of DIA , we were allowed to designate four (4) federal special focus facilities. It is my understanding that every state has been cut by CMS in allowable special focus facility designees , Iowa was cut to two (2). The Committee should change this to allow additional special focus facility designations, and accompanying oversight. At that time, states were given the opportunity to choose, from a CMS provided list, the facilities they wished to designate. CMS' algorithm for compiling this list was never made known to the State Survey Agency. The chosen special focus facility was to be surveyed more frequently than the ordinary twelve (12) month, no later than fifteen (15) month schedule, and the facility was to be timely decertified if certain deficient practices were found.

The Committee may wish to examine the SFFP, and CMS' handling of it. The Abbey of Le Mars, Iowa, is the facility (noted above) that settled the Northern District's Federal False Claims Act case against it. This facility had remained on the special focus facility list for over two (2) years, during which time residents continued to be harmed. A related concern to the SFFP is the reluctance of CMS to actually decertify a facility. In order to receive, and maintain certification, a facility must be licensed by the state. There is a complex interrelationship between the revocation of a state license and federal decertification. Appeal rights are also different. The Committee may wish to learn more about the manner by which facilities that are neglecting and abusing residents can/should be eliminated, and the time and effort it takes, all in the interest of Elder Justice.

9. Survey Integrity Thoughts. During my Iowa Survey Agency leadership, DIA worked closely on many nursing home enforcement cases with Assistant Regional Counsel Richard L. Routman in Kansas City, Missouri, US Dept. of HHS. Now retired, living at 106 Church St., Leesburg, VA, 20176, attorney Routman and I collaborated on these thoughts.

Nursing home fraud is a problem, and takes many forms. In order to address some notable concerns, there are several efforts that CMS and its partners might tackle. There are three themes to our thoughts below: (1) Greater coordination and cooperation among federal and state regulators/prosecutors and others; (2) sharpened focus on the integrity of the information received from nursing homes and their staff; and (3) providing better and timely notice to the public of determinations against facilities and adjudicated findings. Making the survey and appeal process more honest/efficient/effective/public will enhance the anti-fraud provisions/proposals set forth below.

This effort should involve conversations between and among State Survey Agency personnel, CMS Regional and Central Office staff, counsel, state Assistant Attorneys General, professional Disciplinary Boards and their staff and counsel, state Ombudsman personnel, US Attorneys/Assistants, MFCU Directors and staff, OGC, OIG, investigators from the Fiscal Intermediary, and others.

We have approached these issues from the various stages of the federal administrative appeal process, all arising out of the state Survey. CMS was given this information.

Prior to the survey

1. All employees at nursing homes, licensed or not, should be mandatory reporters of fraud and false statements regarding medical records and all matters involving survey activity and enforcement.
2. Require licensed persons who are no longer employed by the facility being surveyed to cooperate with federal and state nursing home surveyors, including providing written statements under oath.
3. Require facilities to report to the state when a direct care or licensed staff member quits or is fired whether that event is connected with any allegation of wrongdoing. Contact the former employee prior to the survey for background information.
4. Require an employee to report to the state when he or she quits or is fired as a result of the employee making an allegation of wrongdoing against the facility.
5. If an employee quits or is fired as a result of an allegation of wrongdoing against the facility, the state is entitled to treat that as an "IJ" item, authorizing a Complaint Investigation.
6. Establish a government-only, inter-agency, confidential and password protected website for, among other things, the pre-survey solicitation and exchange of information from any other agency about the facility soon to be surveyed and any/all of its employees.
7. Require the facility to report any claim made on or behalf of a resident, any request for arbitration, or filing of a civil lawsuit commenced in connection with a claim on behalf of a resident or the settlement of any claim on behalf of the resident, within 20 days.
8. Develop and exploit contacts with the relevant plaintiff's bar and fraud units of insurance companies to determine the existence of claims and unusual reimbursement activity.
9. Authorize CMS and the state to be present at the arbitration hearing of any claim against a nursing home or to acquire a copy of the transcript and exhibits, if any.
10. Require that a facility provide a plain-English notice and telephone (including the state hotline number) and email contact information for the state and federal regulators by the signature line of the Admission Contract.
11. Determine from online and other public sources if the private bar has civil actions pending against nursing homes.
12. Contact temporary nursing agencies and determine whether the facility has utilized temporary staff in numbers beyond expected rates.
13. Contact law enforcement and ambulance services to determine if any emergency calls have been made to the facility during the time period in question.

During the survey

1. During the survey, the Surveyors would provide the Administrator, the Director of Nurses, and others, a written questionnaire to be signed, *under oath,* attesting to their knowledge that: (a) No false or altered documents have been created or used in connection with the survey; (b) No false statements by staff are known or believed to have been made to Surveyors; (c) No documents have been destroyed or secreted from the Surveyors; (d) No effort has been made by staff or others to mislead, obstruct, or impede the survey/investigation; (e) Whatever affirmative representation the Surveyor wishes to be made by staff regarding the specifics of the survey findings.
2. If the facility staff decline to sign the questionnaire, have in place a protocol with the US Attorney for seeking a temporary restraining order or other remedy.
3. The Surveyors should routinely gather information identifying former staff (and how they can be reached and the circumstances of their separation from the facility).
4. Introduce the option to Surveyors of using computer recording of interviews.
5. Authorize CMS to require information from the Quality Improvement Organization (QIO) with respect to any training or review the QIO has conducted at the facility within the past relevant period.
6. Authorize CMS to require that the OIG provide information with respect to the facility's operations if a Corporate Integrity Agreement is, or was, in place with that facility during the relevant period.
7. Require the facility to produce, on CMS' request, all intra-staff (including any corporate nurse and any corporate officer or employee) email relating to the deficiencies or the survey being conducted, both before and during the survey—without interfering in the facility's attorney-client relationship.

8. Require the facility to produce the underlying computer codes to CMS where the nurses' notes and other facility records are generated by computer and not in handwritten form.
9. Determine the frequency of the facility using agency or temporary direct care staff.
10. Determine corporate affiliations with other providers of goods and services, *i.e.*, is the pharmacy a division or subsidiary of the corporation that owns the facility.
11. Require that outside providers, such as Physicians and others, must cooperate with the Surveyors as a contractual condition of doing business with the facility.
12. Contact the volunteers and staff of the Long Term Care Ombudsman's Office for the facility and solicit information.
13. Contact the facility's pharmacy to determine if there are any issues involving medication procedures.

Before and at the Informal Dispute Resolution (IDR) Hearing

1. Have the state attorney submit written questions to the facility in advance of the IDR with the request that the facility address those questions at the IDR. Adopt rules requiring the facility to answer those questions at IDR.
2. Tape record the IDR.
3. Place attendees under oath at the IDR.
4. Use IDR for discovery.
5. Make the IDR public.

After the survey, while the appeal is pending

1. Consider having the state proceed first with its parallel licensure proceeding. Since the state procedures may allow it, discovery could occur. If the state prevails, it will be possible for CMS to argue claim preclusion against the facility in the federal case.
2. Have the Surveyors provide a private report to CMS attorneys about impressions, suspicions, and matters calling for further investigation while the appeal is pending.
3. Establish a protocol for dealing with suspected false documents, obstruction of the audit, or other fraud, including: (a) in the state proceeding, subpoenaing the attorneys' file and making a showing that the facility is using legal services to perpetrate a fraud, thereby (arguably) vitiating the confidentiality of attorney-client communications or (b) in the federal proceeding, requesting the ALJ to issue a subpoena against the facility's attorneys and make the required showing under federal law that the attorney-client privilege is lost under these circumstances.
4. Require the state to advise CMS of the pendency of any other state proceeding against the same facility involving allegations in common with the federal appeal, including abuse hearings.
5. Call for procedures requiring state professional disciplinary boards to initiate investigations promptly, gather statements under oath and coordinate their investigations with other state and federal enforcement agencies, including sharing of information.
6. Authorize the ALJ to order production of documents immediately if there is a clear entitlement to them. No need to wait until the hearing.

At the hearing

1. Provide for public notice of the hearing in the local newspaper and a posted notice in the facility to invite members of the public to attend the hearing.
2. Authorize the ALJ to increase the monetary penalty for fraud, or other good cause.
3. Authorize the ALJ to impose a penalty, including the imposition of attorneys' fees and costs, on the facility or, if appropriate, on its attorneys for lack of a reasonable or substantial justification for appealing the deficiency. (This is analogous to the Equal Access to Justice Act burden the government has to show that it was substantially justified in its position even if it lost; also see Rule 11, F.R. Civ. P., and the statute prohibiting attorneys from multiplying the proceedings.)
4. Once the hearing date is scheduled or, in those cases where the direct testimony must be submitted in advance in writing, prior to the deadline for the first submission of such written testimony, the facility cannot dismiss or withdraw the appeal and CMS cannot alter the remedy or discontinue the case without the permission of all parties or by Order of the ALJ who must find

good cause for dismissal. (This aligns to the federal rule of civil procedure on voluntary dismissals.) Sanctions can be imposed if good cause is not shown.

5. Require the facility to include the transcript of the hearing on its website or make it available upon request by any person.

If the case settles

1. By the terms of the settlement, the facility and its employees must agree to cooperate with future investigations or surveys regarding other facilities or persons.
2. The terms of the settlement should contain creative prospective performance and reporting requirements which address the deficiencies being settled, including staffing ratios, in-servicing, periodic reports, surprise inspections and surveys, appointment of monitors, increases in staff compensation, disclosure of executive compensation, and others.
3. Establish a protocol for making concessions to a defendant in exchange for information evidencing deficiencies or fraudulent conduct by others in connection with nursing home care at any facility.
4. No bonuses for management for future deficiency-free surveys.

After the hearing

1. Provide information to other agencies or professional boards for possible further action; conduct follow-up to determine whether additional sanctions were imposed.
2. Track the employment of suspected deficient staff and monitor their performance in future surveys.

Some related legislative and regulatory proposals

1. Clarify and strengthen the protocols for requiring ombudsman staff and volunteers to report fraud and suspected deficiencies to the state Survey Agency.
2. Confirm that the quality assurance privilege does not protect any facility document, other than the committee minutes of the quality assurance committee. At least, provide clarification regarding the privilege.
3. Seek legislative approval for CMS to propound written discovery against facilities in administrative appeals.
4. Require a facility to respond fully and accurately in writing to the request of another facility considering hiring a person once employed at the facility, especially if the person were discharged due to substandard or abusive conduct. Provide immunity against suit by the former employee.
5. Require local, state and federal criminal law enforcement officials (including county medical examiners) to report to the state Survey Agency any information regarding reported elopements, assault, rape, suspicious deaths or other possible violations.
6. Define and allow the imposition of sanctions against corporate officers and directors.
7. Remove the dischargeability of claims under bankruptcy laws of any successful claim against a nursing home or its officers and directors for violating or participating in the violation of federal anti-fraud/abuse nursing home regulations.
8. Prohibit bonuses for management for future clear surveys.
9. Add a fraud tag, or several defining tags, so that Surveyors can add that as a deficiency to the administrative proceeding.
10. Prohibit the use of any pre-dispute binding arbitration clauses in admission documents.
11. Require disclosure of related-party transactions between the facility (or its owner) and other companies or persons.
12. Require the ALJs to issue rulings within a reasonable period of time following the hearing, not to exceed six months following the filing of briefs.
13. Make it illegal to offer or pay any inducements to or to threaten retaliation or to retaliate in any way against any current or former employee of a nursing home for refusing to disclose or disclosing information to government authorities regarding the operation of the facility. Add an lJ tag/tags for such action.
14. Create similar provisions related to inducements/threats to residents, family, visitors, and others.

10. Miscellaneous legislative proposals, some related to items 1–8 above

1. Define and require disclosure of profits, establish parameters for profit-taking, establish guide lines for salaries and benefits of owners, management, executive staff, and others.

2. Forbid government payments, directly or indirectly, to industry Associations.
3. Study, and limit government payments made directly or indirectly to facility attorneys challenging government action and performing other services. Allow only reasonable hourly rates, only upon successful challenges and only for legal work directly related to resident care.
4. Require sworn Cost Reporting.
5. Mandate staffing levels for RNs, LPNs, CNAs.
6. Require CMS to develop a team of nationally certified Surveyor Specialists who will travel to State Survey Agencies throughout the Country for the purpose of training Surveyors and assisting with surveys of poor performing facilities.
7. Require State Survey Agencies to create Abuse Coordinating Units to work with MFCU's and law enforcement on issues of abuse and neglect.

NATIONAL ASSOCIATION OF STATE LONG-TERM CARE OMBUDSMAN PROGRAMS

August 5, 2019

U.S. Senate
Committee on Finance
Dirksen Senate Office Building
Washington, DC 20510–6200

RE: Senate Finance Committee Hearing: "Promoting Elder Justice: A Call for Reform," July 23, 2019

Chairman Grassley and Ranking Member Wyden:

Introduction

The National Association of State Long-Term Care Ombudsman Programs (NASOP) extends its thanks to the chairman, ranking member and committee members for the hearing held on July 23, 2019 continuing to focus on elder justice including protections for residents of long-term care facilities. Congress has an opp01tunity to improve the protections for older adults by reauthorizing the Elder Justice Act, and protections for nursing home residents by requiring stronger enforcement of the current protections provided in the Nursing Home Reform Act known as the Omnibus Budget Reform Act of 1987 and the accompanying nursing home regulations.

NASOP agrees with the concerns raised by Chairman Grassley and Ranking Member Wyden that the nursing home rating system does not provide all of the information that individuals and their families need when choosing a nursing home. For example, the rating system should include how often the information is updated, which information is self-reported by each facility, requiring abuse deficiencies to be reported in the rating system, and warning that the rating system should not be the only consideration when choosing a nursing home.

NASOP also agrees with a number of concerns raised by the witnesses at the hearing and makes the following recommendations.

Immediately Reporting Abuse Allegations to Law Enforcement

As the Government Accountability Office (GAO) report points out, delays in responding to abuse allegations result in the loss of evidence, the inability to substantiate the complaint, and the potential to allow a perpetrator to continue abusing residents. Congress should clarify the definition of abuse and require that abuse allegations be reported to law enforcement by nursing homes, the survey agency, hospital personnel, and other mandatory reporters at the time the allegation is made or evidence of abuse is discovered. Law enforcement officers are trained to investigate crimes, including abuse. Safety of the residents is of paramount importance. Confirming the crime occurred, and identifying and arresting the perpetrator should be the first priority. Whether the survey agency is able to verify that the facility engaged in a deficient practice is an important and related issue. In addition, some meaningful sanctions should be provided for failure to report, or failure to report timely. Such sanctions could be the suspension of a professional license, significant fines, or other penalties.

Amend the Privacy Act to Allow Sharing of Survey Agency Information

Congress should take action, whether amending the Privacy Act or through other legislation to require the Centers for Medicare and Medicaid Services (CMS) and the survey agencies with whom they contract, to share unredacted information of its in-

vestigations with law enforcement and prosecutors, if a crime is involved, and with the Long-Term Care Ombudsman Program for all of its investigations.

Use the GAO Recommendations in Legislation

In addition, Congress should create legislation that builds on the six recommendations that are included in the GAO report and to which CMS has agreed. Summarizing those six recommendations and expanding on them, they include (1) require state survey agencies to report abuse and perpetrator type to CMS's database for deficiency, complaint and facility reported incident data, require CMS to analyze the data for trends, and require CMS to annually report those trends to Congress and the public; (2) develop and disseminate a standardized form for facility-reported incidents; (3) require the survey agencies to immediately refer abuse allegations to law enforcement at the time the allegation is made; (4) require CMS to conduct oversight to assure that state survey agencies are making referrals to law enforcement; (5) require survey agencies to report to law enforcement and state registries when the survey agencies substantiate allegations even if the state agencies do not cite a federal deficiency; and (6) require CMS to confer with law enforcement agencies to develop and provide requirements for what must be included in abuse allegation referrals to law enforcement.

Further Legislation Related to Abuse Deficiencies

Congress should require CMS and the survey agencies to impose and implement enforcement actions for abuse deficiencies. Congress should require that abuse deficiencies must be cited and made public, even if the facility subsequently corrects the deficient practice. It is simply not enough that a nursing home corrects its deficient practice; when abuse happens it must be made public.

Supporting Survey Agencies in Sanctioning Nursing Homes

The agencies tasked with surveying nursing homes must be supported when they find deficiencies and determine that sanctions are appropriate. Congress should require CMS to support the survey agencies' scope and severity findings or publicly provide clear reasons when it does not, and require per diem fines, rather than per instance fines.

Adding Professionals to Criminal Background Checks

Congress should add the recommendation from the American Health Care Association to require facilities to check the National Practitioner Data Bank in addition to completing a fingerprint criminal background check for all nursing home staff. In addition, Congress should amend the National Background Check Program to make it a Requirement of Participation for nursing homes certified by Medicare and Medicaid. Congress could move the program from CMS to the Department of Justice (DOJ) because background checks are a more consistent with DOJ expertise.

Minimum Staffing Ratios

Congress should set a minimum staffing ratio to residents and require that facilities staff above the minimum to meet the residents' needs. Minimum staffing ratios could help reduce the incidence of abuse. Some reasons given for resident abuse include staff members losing their tempers when they are short staffed and stretched too thinly; or not enough staff are able to supervise residents who may become aggressive when their needs are not being met. In addition, a minimum ratio of staff to residents should allow staff more time to notice when a resident has changed care needs that require additional interventions. Lastly, it adds transparency to the process. With a required minimum staff to resident ratio for every day of the week, residents, family members, facility staff, surveyors and the public know what the minimum number of staff should be.

Conclusion

After these hearings, the Senate has identified some needed changes to combat abuse of older adults and individuals with disabilities. Reauthorizing and fully funding the Elder Justice Act and making changes to improve enforcement of resident protections would make quality of life better and safer for nursing home residents.

Sincerely,

Melanie S. McNeil

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July 23, 2019

U.S. Senate
Committee on Finance
Dirksen Senate Office Bldg.
Washington, DC 20510–6200

Regarding "Promoting Elder Justice: A Call for Reform," July 23, 2019

On behalf of the New Hampshire Health Care Association, representing long-term care facilities capable of serving over 7,100 residents, I offer the following thoughts concerning your hearing.

New Hampshire has the nation's lowest unemployment rate, second-oldest population, and New England's largest gap between Medicaid payments and costs for nursing home care. Funding has not even kept pace with the Consumer Price Index. The state budget is "balanced" on caregivers' backs due to years of state policymaker neglect.

The nation's entire nursing home care sector cannot be painted with the same brush, and we resent any efforts to do so. In New Hampshire we work very collaboratively, and proactively, with our state government on maintaining quality amidst funding adversity and the recruitment, and retention, challenges inadequate Medicaid funding creates. Regardless of those challenges, abuse and neglect is intolerable and we would *never* excuse it.

In March, the annual report to Congress from the Medicare Payment Advisory Commission found the average nursing home margin nationally fell to .5% in 2017. And yet, astonishingly, some would have made this crisis even worse. Chairman Grassley would have eviscerated the Medicaid program under the guise of "repealing-and-replacing" the Affordable Care Act. To quote Chairman Grassley from a September 20, 2017 *Des Moines Register* article:

> "You know, I could maybe give you 10 reasons why this bill shouldn't be considered," Grassley said. "But Republicans campaigned on this so often that you have a responsibility to carry out what you said in the campaign. That's pretty much as much of a reason as the substance of the bill."

We are grateful that efforts to effectively destroy Medicaid long-term care failed. We would ask that members of the Senate Finance Committee *assist* states like New Hampshire, rather than simply pillory care. We don't have the luxury here, as do the states of the chairman and the ranking member, of the federal government covering 61.2% of the cost of care. The income based Federal Medical Assistance Percentage is only 50% for New Hampshire, and does not account for the fact that our state, with no personal income tax, has no way of capturing personal income.

We would note that the Trump Administration's immigration restrictions will further constrain our nation's fragile long-term care system's ability to serve an aging society.

It is demoralizing for our hard-working staff to see their work further undervalued by federal lawmakers who refuse to provide funding that matches their rhetoric. We look forward to the day when a hearing is held to address their needs and dedication, however unlikely that may be.

I enclose, for the record, a copy of a recent article of mine in the *Seton Hall Legislative Journal* about the challenging environment for long-term care.

Best regards,

Brendan Williams
President/CEO

Enclosure

Failure to Thrive? Long-Term Care's Tenuous Long-Term Future.

Brendan Williams*

I. INTRODUCTION

According to the U.S. Census, by 2030, there will be an estimated three million more residents aged 85 and older than there were in 2012.[1] The Urban Institute estimated that "about fifty percent of the population ages 85 and older has a disability, compared with only 10 percent of the population ages 65 to 74."[2] This growing demographic will have long-term care needs, resulting in serious Medicaid cost implications for states.

What are we doing as a nation to prepare for this "Silver Tsunami"? The answer is simple: effectively nothing. The federal government has made no substantive effort to address our aging future since the Community Living Assistance Services and Supports (CLASS) Act was included in the 2010 Patient Protection and Affordable Care Act (ACA).[3] In 2011, the Obama Administration abandoned CLASS after determining that it was "financially unsustainable."[4] CLASS would have provided long-term care benefits that voluntary payroll contributions would have financed.[5] Congress took bipartisan action to repeal CLASS as part of the American Taxpayer Relief Act of 2012 (Taxpayer Relief Act).[6] The Taxpayer Relief Act created a Commission on Long-Term Care.[7] The Commission's ambitious task was to "develop a plan for the establishment, implementation, and financing of a comprehensive, coordinated, and high-quality system that ensures the availability of long-term services and supports for individuals in need of such services and supports."[8] It was intended to benefit the elderly, those with "substantial cognitive or functional limitations," those needing help performing daily activities, and those wanting a long-term care plan.[9] Predictably, the 2013 report to Congress noted, "The Commission did not agree on a financing approach, and, therefore, makes no recommendation."[10] For example, the Commission considered, but ultimately did not agree upon, creating a long-term care benefit within Medicare.[11]

Meanwhile, with no national plan to address our current, let alone future, long-term care needs, the federal deficit is exploding due to President Trump's tax cuts.[12] This could potentially create a collision between demographic needs and resources, and policymakers have made it clear where their priorities lie. For example, former U.S. House Speaker Paul Ryan. (R–WI) asserted that "it's the health care entitlements that are the big drivers of our debt, so we spend more time on the health care entitlements—because that's really where the problem lies, fiscally speaking."[13]

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[1] *See, e.g.,* Jennifer M. Ortman et al., "An Aging Nation: The Older Population in the United States," U.S. Census Bureau (2014), *https://www.census.gov/prod/2014pubs/p25-1140.pdf.*

[2] Richard W. Johnson et al., "Meeting the Long-Term Care Needs of the Baby Roomers," The Retirement Project (2007), *https://www.urban.org/sites/default/files/publication/43026/311451-Meeting-the-Long-Term-Care-Needs-of-the-Baby-Boomers.pdf; see* Kaiser Family Foundation, "Medicaid's Role for Seniors" (2017), *http://files.kff.org/attachment/Infographic-Medicaids-Role-for-Seniors* (estimating that 74 percent of those 85 and older have a long-term care need).

[3] Patient Protection and Affordable Care Act, Pub. L. No. 111–148, 124 Stat. 119 (2010).

[4] *See, e.g.,* Jason Kane, "What the Death of the CLASS Act Means for Long-Term Disability Care," PBS (October 14, 2011), *https://www.pbs.org/newshour/health/what-the-death-of-the-class-act-means-for-long-term-disability-care.*

[5] *Id.*

[6] *See* American Taxpayer Relief Act of 2012, Pub. L. No. 112–240 § 642, 126 Stat. 2313, 2358.

[7] *See id.* § 643(a).

[8] *Id.*

[9] *Id.* § 643(b).

[10] U.S. Senate Committee on Long-Term Care, Report to the Congress 61 (2013), *http://Itccommission.org/Itccommission/wp-content/uploads/2013/12/Commission-on-Long-Term-Care-Final-Report-9-26-13.pdf.*

[11] *Id.* at 66–68.

[12] *See, e.g.,* Jim Tankersley, "How the Trump Tax Cut Is Helping to Push the Federal Deficit to $1 Trillion," *New York Times* (July 25, 2018), *https://www.nytimes.com/2018/07/25/business/trump-corporate-tax-cut-deficit.html* ("The Trump administration had said that the tax cuts would pay for themselves by generating increased revenue from faster economic growth, but the White House has acknowledged in recent weeks that the deficit is growing faster than it had expected.").

[13] Jeff Stein, "Ryan Says Republicans to Target Welfare, Medicare, Medicaid Spending in 2018," *Washington Post* (December 6, 2017), *https://www.washingtonpost.com/news/wonk/wp/*

Continued

Medicaid is a state and federal partnership. Each state receives a federal match of no less than one dollar for every dollar spent on Medicaid, based upon "per capita income"—poorer states receive more, and wealthier states receive less.[14] Lately, while most public and political attention has focused on Medicaid expansion under the ACA, "legacy" or "traditional" Medicaid has funded long-term care for decades.[15]

Medicaid's vital safety net faces existential threats, largely as a result of two successive presidents' indifference towards Medicaid.[16] The nation has come a distance from the compassion that President Lyndon Johnson demonstrated in signing Medicare and Medicaid into law in the library of President Harry Truman, handing out 72 pens used to sign the measure.[17] Johnson promised that "no longer will this nation refuse the hand of justice to those who have given a lifetime of service and wisdom and labor to the progress of this progressive country."[18] In an emotional speech, Johnson stated, "There are those alone in suffering who will now hear the sound of some approaching footsteps coming to help."[19]

However, Johnson's lofty ideals in 1965 got in the way of today's parsimony toward the poor. In 2015, at the urging of the Obama Administration and state governments, the U.S. Supreme Court held that providers did not have standing to sue over Medicaid cuts in *Armstrong v. Exceptional Child Center, Inc.*[20] Siding with the majority in the 5–4 decision, Justice Breyer rhapsodized "that administrative agencies are far better suited to this task than judges."[21] Thus, only the U.S. Centers for Medicare and Medicaid Services (CMS), under the U.S. Department of Health

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2017/12/01/gop-eyes-post-tax-cut-changes-to-welfare-medicare-and-social-security/?noredirect=on&utm_term=.f73f06fe4d79 (Although Ryan is no longer in office, this conservative philosophy lives on.).

[14] *See* 42 U.S.C. § 1396d(b) (2012). This has the unintended effect of allowing poorer states to further reduce taxes at the expense of "donor" states. Brendan Williams, "My Turn: A Fairer Return on Federal Dollars for NH," *Concord Monitor* (July 13, 2016), *https://www.concordmonitor.com/N-H-Medicaid-funding-3398300* ("For every dollar New Hampshire spends on Medicaid it receives one federal dollar—evenly splitting the responsibility. In contrast, in Mississippi the federal government pays 74.6% of the Medicaid bill. This subsidy from states like New Hampshire allows policymakers in poorer states to more easily fund Medicaid while crowing about their fiscal conservatism.").

[15] Traditional Medicaid was also under assault in legislation that just ostensibly sought to repeal and replace the ACA. *See* Dylan Scott, "How Medicaid Became the Most Important Battleground in American Health Care," *Vox* (November 10, 2017), *https://www.vox.com/policy-and-politics/2017/11/10/16118644/medicaid-future* ("Medicaid, long the forgotten sibling of our social safety net, has now become the central battleground in the fight over America's social compact."). Under spending caps that came close to congressional passage, "Medicaid spending would have been cut by 35 percent, versus current law, after 2 decades of those spending caps." *Id.* CMS Administrator Seema Verma continues to advocate for implementing limits on Medicaid spending. Priyanka Dayal McCluskey, "Medicaid Needs to Change, Head of Program Says in Boston, and That Includes Spending Caps," *Boston Globe* (April 25, 2018), *https://www.bostonglobe.com/business/2018/04/25/medicaid-needs-change-trump-head-program-says-boston/BnjdhASdGtHEdQxxybC6qO/story.html* ("Spending limits could be imposed on a per-patient basis, or per state. State spending caps are known as block grants."). These artificial caps would be disastrous given the inexorability of the coming age wave. State parsimony has been enough of a "cap" without limiting federal matching funds and creating a disincentive for states to spend. But tragic consequences are unlikely to dissuade the current administration. *See* Brendan Williams, "Medicaid Cuts Are the Real 'Death Panels'," *USA Today* (April 28, 2017), *https://www.usatoday.com/story/opinion/2017/04/28/medicaid-cuts-real-death-panels-column/100939932/* ("Seema Verma designed an Iowa managed care system with disastrous new administrative burdens, payment delays and denials for providers—along with massive state cost overruns."). At the same time Verma seeks to cut Medicaid funding, she is seeking to increase nursing home staffing with no new Medicaid funding to pay for it. *See* Press Release, U.S. Centers for Medicare and Medicaid Services, CMS Strengthens Nursing Home Oversight and Safety to Ensure Adequate Staffing (November 30, 2018). This could create a perfect staffing crisis storm. In New Hampshire, for example, Medicaid rates were only going up an average of .11 percent on January 1, 2019, equal to 7 cents per resident, per day, in a state with the third-lowest unemployment rate. *See* Brendan Williams, "Lawmakers Must Address Medicaid Funding Neglect," *Concord Monitor* (November 21, 2018), *https://www.concordmonitor.com/Medicare-payments-21678575.*

[16] *See, e.g.,* Brendan Williams, "How the Obama administration made it possible to gut Medicaid," *The Hill* (June 12, 2017), *https://thehill.com/blogs/pundits-blog/healthcare/337467-how-the-obama-administration-made-it-possible-to-gut-medicaid.*

[17] *See* John D. Morris, "President Signs Medicare Bill; Praises Truman," *New York Times* (July 31, 1965), *https://timesmachine.nytimes.com/timesmachine/1965/07/31/101558385.pdf.*

[18] "Transcript of Remarks by Truman and Johnson on Medicare," *New York Times* (July 31, 2015), *https://timesmachine.nytimes.com/timesmachine/1965/07/31/101558459.pdf.*

[19] *Id.*

[20] 135 S. Ct. 1378, 1384 (2015).

[21] *Id.* at 1388 (Breyer, J., concurring in part and concurring in the judgment).

and Human Services, was the proper arbiter of providers' Medicaid underfunding claims.

In its brief, the Obama Administration stated:

> The reimbursement relationship between a State and a provider is essentially contractual in nature. It would be anomalous for one party to a prospective or existing contract (a provider) to have a legal *right*—a cause of action—to insist that the other party (the State) increase its offer for a future contract or to increase its payments under an existing contract.[22]

This was a rather disingenuous argument, for where *else* would a remedy lie but in court? Medicaid contracts are effectively contracts of adhesion, where there is an enormous imbalance of power between the contracting parties—contracts are presented on a take-it-or-leave-it basis. For example, if 62 percent of those whom a provider is caring for are on Medicaid, as is true for nursing homes on average, how can a provider simply refuse a non-negotiable Medicaid contract?[23]

Congressional Democrats, including House Minority Leader Nancy Pelosi (D–CA) and then-Senate Majority Leader Harry Reid (D–NV), filed their own brief with the Court, disagreeing with the Obama Administration's position: "[t]his case implicates . . . the right to seek equitable relief under the Supremacy Clause against state law that is inconsistent with Congressional enactments."[24] Under their interpretation, the law "provides impoverished, developmentally disabled Medicaid patients and the medical providers who serve them a means of redress in the court system that they would often not have in the political battles over budget priorities."[25]

From his ivory tower, Justice Breyer apparently did not foresee the unhappy marriage of administrative deference with a Trump Administration that disfavors administrative oversight, when he cast his deciding vote in *Armstrong*.[26]

In March 2018, under the guise of furthering "President Trump's commitment to 'cutting the red tape' by relieving states of burdensome paperwork requirements," CMS proposed a rule to allow states with managed care insurers running their Medicaid programs to more freely cut Medicaid rates—by up to "4% percent in overall service category spending during a State fiscal year (and 6% over two consecutive years)"—*without federal oversight.*[27] In its proposed rule, CMS states, "We continue to believe that changes below 4 percent are generally nominal[.]"[28] Indeed, CMS states:

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[22] Brief for the United States as Amicus Curiae Supporting Petitioners at 31, *Armstrong vs. Exceptional Child Center,* 135 S. Ct. 1378 (2015) (No. 14–15).

[23] *See* Kaiser Family Foundation, "Medicaid's Role in Nursing Home Care" (June 20, 2017), *https://www.kff.org/infographic/medicaids-role-in-nursing-home-care/;* Jessica Wheeler, *"Armstrong vs. Exceptional Child Center:* Who Should Enforce Equal Access?", *Minnesota Law Review* (December 22, 2017), *http://www.minnesotalawreview.org/2017/12/armstrong-v-exceptional-child-center/* ("If one believes Medicaid beneficiaries should get the same access to health care as the general public, allowing providers to bring private enforcement actions is the most efficient way to ensure it.").

[24] Brief of Members of Congress as Amici Curiae in Support of Respondents at 2, *Armstrong vs. Exceptional Child Center,* 135 S. Ct. 1378 (2015) (No. 14–15).

[25] *Id.* at 15.

[26] *See, e.g.,* Alan Levin and Alyza Sebenius, "Trump Claims $1.6 Billion a Year Saved From Cutting Red Tape," *Bloomberg* (October 16, 2018), *https://www.bloomberg.com/news/articles/2018-10-17/trump-administration-claims-23-billion-in-regulation-savings.*

[27] Press Release, U.S. Centers for Medicare and Medicaid Services, "CMS Proposes Regulation to Alleviate State Burden" (May 22, 2018), *https://www.cms.gov/newsroom/press-releases/cms-proposes-regulation-alleviate-state-burden.* Many states have turned over their Medicaid programs to managed care insurers, despite the lack of any empirical evidence that this improves care. *See, e.g.,* Brendan Williams, "Leap of Faith: Managed Care and the Privatization of Long-Term Care Services," 30 *Loyola Consumer Law Review* 438, 438–459 (2018). These insurers are intent on maximizing profit to the detriment of providers and beneficiaries alike, going so far, for example, as to deny wheelchairs to Iowans with disabilities despite physician and state orders to provide them. *See* Jason Clayworth, "Iowa Medicaid Company Forced to Provide Special Wheelchairs to Disabled Clients," *Des Moines Register* (August 20, 2018), *https://www.desmoinesregister.com/story/news/investigations/2018/08/20/provide-them-wheelchairs-judges-teLL-iowa-medicaid-company/976986002/* ("[A]ppeals by United Healthcare—each involving a severely disabled Iowan who can't walk independently—lingered for more than a year while the managed care provider denied doctor and state orders that it pay for the specialized equipment.").

[28] Medicaid Program; Methods for Assuring Access to Covered Medicaid Services—Exemptions for States With High Managed Care Penetration Rates and Rate Reduction Threshold, 83 Fed. Reg. 12696, 12698 (March 23, 2018) (to be codified at 42 CFR part 447).

> We are requesting comments to determine whether the nominal threshold should be higher or lower than 4 percent for a single SFY and 6 percent for 2 consecutive SFYs, recognizing that state legislatures need sufficient flexibility to manage budgets and make adjustments to Medicaid spending that are unlikely to result in diminished access to care for program beneficiaries.[29]

As Professor Andy Schneider of Georgetown University wrote, "The underlying philosophy seems to be 'don't ask, don't know.' The federal courts will no longer hear provider challenges to low payment rates, and now CMS no longer wants information on the effect of payment cuts so that it can do its job."[30]

Increasingly, those needing assistance with the activities of daily living have alternatives to nursing home care, where such alternatives can meet their needs. A May 2018 report noted that "[h]ome and community-based services (HCBS) have accounted for almost all Medicaid LTSS growth in recent years while institutional service expenditures remained close to the FY 2010 amount."[31] In 2016, HCBS spending accounted for 57 percent of Medicaid long-term care spending.[32] This proportion was as high as 81 percent for Oregon and as low as 27 percent for Mississippi.[33]

Yet, the entire continuum of long-term care faces severe challenges, even before the coming age wave crashes upon states' budgetary shores.

It is not as if older Americans are saving enough to avoid Medicaid. As one article reported in August 2018, "The rate at which Americans at least 75-years-old filed for bankruptcy more than tripled from 1991 to 2016, while filings among those between 65 and 74 ballooned more than 200 percent, according to a recent study from a group of professors working with data from the Consumer Bankruptcy Project."[34] Further, of those filing for bankruptcy, "about three in five said unmanageable medical expenses played a role."[35]

This trend will only get worse, as Americans lack retirement resources. A 2014 *Time* article noted that "[b]ecause defined benefit plans are more costly for employers than defined contribution plans, most of them have—you guessed it—scaled back dramatically or eliminated these plans altogether in recent years."[36] A 2018 *Atlantic* article reported that "the median savings in a 401(k) plan for people between the ages of 55 and 64 is currently just $15,000, according to the National Institute on Retirement Security, a nonprofit."[37] As the article noted, "the current wave of senior poverty could just be the beginning. Two-thirds of Americans don't contribute any money to a 40l(k) or other retirement account, according to Census Bureau researchers."[38] Two writers in the *Harvard Business Review* "predict the U.S. will soon be facing rates of elder poverty unseen since the Great Depression[.]"[39] Meanwhile,

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[29] *Id.* at 12699. What about the ability of Medicaid providers "to manage budgets"?

[30] Andy Schneider, "'Rolling Back' the Medicaid Access Rule: Don't Ask, Don't Know," *Say Ahhh!* (April 2, 2018), *https://ccf.georgetown.edu/2018/04/02/rolling-back-the-medicaid-access-rule-dont-ask-dont-know/*.

[31] Steve Eiken et al., "Medicaid Expenditures for Long-Term Services and Supports in FY 2016," *IBM Watson Health* (2018), *https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpenditures2016.pdf.*

[32] *See id.* at 6.

[33] *See id.* at 7.

[34] Andrew Soergel, "Bankruptcy Soars Among Elderly as Inequality Deepens," *U.S. News and World Report* (August 8, 2018), *https://www.usnews.com/news/data-mine/articles/2018-08-08/bankruptcy-soars-among-elderly-as-inequality-deepens.*

[35] Tara Siegel Bernard, "'Too Little Too Late': Bankruptcy Booms Among Older Americans," *New York Times* (August 5, 2018), *https://www.nytimes.com/2018/08/05/business/bankruptcy-older-americans.html.*

[36] "What Is the Difference Between a Defined Benefit Plan and a Defined Contribution Plan?", *Time* (May 20, 2014), *http://time.com/money/2791222/difference-between-defined-benefit-plan-and-defined-contribution-plan/*. Policymakers of both parties have abetted this practice. In 2015, in the progressive State of Washington, even a Democratic governor browbeat aerospace machinists into giving up defined-benefit pensions in their contract negotiations with Boeing. *See, e.g.,* Jim Brunner, "Labor Group Disinvites Inslee Over Boeing Tensions," *Seattle Times* (July 20, 2015), *https://www.seattletimes.com/seattle-news/politics/labor-group-disinvites-inslee-over-boeing-tensions/*.

[37] Alana Semuels, "This is What Life Without Retirement Savings Looks Like," *The Atlantic* (February 22, 2018), *https://www.theatlantic.com/business/archive/2018/02/pensions-safety-net-california/553970/*.

[38] *Id.*

[39] Teresa Ghilarducci and Tony James, "Americans Haven't Saved Enough for Retirement. What Are We Going to Do About It?", *Harvard Business Review* (March 28, 2018), *https://*

"[t]here's one area where the traditional pension plan is getting new life: as a tax dodge for wealthy business owners."[40]

This article addresses funding for the continuum of long-term care through nursing homes, assisted living facilities, and in-home care. Next, the article offers some thoughts on how to address the governmental costs of long-term care and secure a more stable future.

II. Long-Term Care's Challenged Continuum

A. Nursing Homes

Once the default choice for long-term care, today, nursing homes (often called "skilled nursing facilities") are generally reserved for truly-debilitated Medicaid long-term care beneficiaries; in 2014, 63.1 percent of nursing home residents needed assistance with at least four out of five daily living activities.[41] In eight states, at least half of the residents were 85-years-old or older.[42] Perhaps more amazingly, in 10 states, between 10.2 percent and 13.3 percent of residents were *95 years old or older*.[43] Most residents had moderate to severe cognitive impairment.[44] Given that women live longer, they comprised the majority of residents—65.6 percent.[45]

The Medicare Payment Advisory Commission's annual report to Congress found that in 2016, nursing home services were operating only at a .7 percent margin, down from 1.6 percent in 2015—or actually in the negative (−2.3%) if Medicare payments were excluded.[46] Nationally, Medicaid spending on nursing home care only went up .9 percent in 2016 and .7 percent in 2017.[47]

How has the federal government responded to this funding crisis? It has piled on more regulations; although, as this author once argued, "[s]hort of nuclear reactors, nursing homes may be the most regulated industry-down to the water temperature."[48] The new federal regulations, which one proponent exulted would mean "[ab]out 1.4 million people living in nursing homes across the country can now be more involved in their care,"[49] carry a cost that the federal government projected is "about $831 million in the first year and $736 million per year for subsequent years. While this is a large amount in total, the average cost per facility is estimated to be approximately $62,900 in the first year and $55,000 in subsequent years."[50]

As to the unfunded cost burden, CMS dismissed it: "We understand that for some facilities Medicaid reimbursement accounts for a large portion of its funding, however the specifics regarding Medicaid funding is regulated by the State and outside

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hbr.org/2018/03/americans-havent-saved-enough-for-retirement-what-are-we-going-to-do-about-it.

[40] Ben Steverman, "Rich Business Owners Are Using Pension Plans to Stash Money and Get a Tax Break," *Los Angeles Times* (August 15, 2018), *https://www.latimes.com/business/la-fi-pension-tax-deduction-20180815-story.html.*

[41] U.S. Centers for Medicare and Medicaid Services, Nursing Home Data Compendium 2015 Edition 156, *https://www.cms.gov/Medicare/Provider-EnrollmentandCertification/CertificationandComplianc/Downloads/nursinghomedatacompendium_508-2015.pdf.*

[42] *Id.* at 153.

[43] *Id.* at 154.

[44] *Id.* at 159.

[45] *Id.* at 199. That proportion is highest in Rhode Island (71.6 percent) and New Hampshire (71.4 percent). *Id.*

[46] Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy" 207 (2018), *http://www.medpac.gov/docs/default-source/reports/mar18_medpac_entirereport_sec.pdf?sfvrsn=0. See* Stephen Campbell, "U.S. Nursing Assistants Employed in Nursing Homes," PHI (2018), *https://phinational.org/resource/u-s-nursing-assistants-employed-in-nursing-homes-2018/(91 percent of their front-line caregivers, nursing assistants, are also women).*

[47] U.S. Centers for Medicare and Medicaid Services, "Nursing Care Facilities and Continuing Care Retirement Communities Expenditures," *https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-andReports/NationalHealthExpendData/NationalHealthAccountsHistorical.html* (open NHE Tables zip file; then open Table 15).

[48] Brendan Williams, "Costly New Medicaid Regs Will Cripple Nursing Homes," *The Hill* (September 10, 2015), *https://thehill.com/blogs/congress-blog/healthcare/253100-costly-new-medicaid-regs-will-cripple-nursing-homes.*

[49] Susan Jaffe, "New Rules Give Nursing Home Residents More Power," *Washington Post* (December 27, 2016), *https://www.washingtonpost.com/national/health-science/new-rules-give-nursing-home-residents-morepower/2016/12/27/c0959f74-c894-11e6-bf4b-2c064d32a4bf_story.html?utm_term=.a2ffb202b7af.*

[50] Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities, 81 Fed. Reg. 68688, 68844 (October 4, 2016).

the scope of this regulation."[51] CMS further stated that "[a]lthough the overall magnitude of cost related to this regulation is economically significant, we note that these costs are significantly less than the amount of Medicare and Medicaid spending for LTC services."[52] Consider that statement. If the average nursing home in 2016 operated at a .7% margin, as the federal government itself reported,[53] then that facility would have needed to generate around $800,000 in income just to afford the $55,000 annual cost that the federal government projected for its new regulations (possibly an understated amount).

The scale of injury that the state governments' knowing failure to pay Medicaid care costs is easiest to assess with nursing homes, as the Balanced Budget Act of 1997 requires states to file detailed cost reports that the states will then audit.[54]

Since nursing homes are more visible, and subject to exacting reporting and survey requirements, they receive bad publicity for issues not uncommon elsewhere among the elderly, such as individual with dementia using antipsychotic (AP) drugs.[55] As the American Association of Retired Persons has found, "While efforts to reduce AP use among dementia patients living in nursing homes are showing some success, less attention is given to older adults living in the community."[56] This study found that AP rates rose between 2012 and 2015 among community-only adults with dementia who were enrolled in Medicare Advantage (MA) plans.[57] According to the National Partnership to Improve Dementia Care in Nursing Homes, "AP use among nursing home residents declined by approximately 34 percent during this time."[58] However, news organizations, like *The Washington Post,* undermine these facts with lurid headlines such as: "Why are nursing homes drugging dementia patients without their consent?"[59]

Such stories make it challenging to focus attention on the need to improve funding. No other healthcare sector is more vulnerable to being defined by anecdotes about single bad actors. Those remembering the devastation inflicted by Hurricane Irma in 2017 may recall the Florida nursing home where residents died from heat-related causes after the hurricane knocked out the facility's air conditioning.[60] However, they are unlikely to even know about every other facility that weathered the storm due to extraordinary staff preparation. Some who remember Hurricane Katrina in 2005 may recall the tragedy of St. Rita's Nursing Home, where 35 resi-

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[51] *Id.* at 68837.

[52] *Id.* at 68844.

[53] *See* Medicare Payment Advisory Commission, *supra* note 46.

[54] Balanced Budget Act of 1997, Pub. L. No. 105–33, 111 Stat. 251 (1997).

[55] *Id.*

[56] Elizabeth A. Carter, "Off-Label Antipsychotic Use in Older Adults with Dementia: Not Just a Nursing Home Problem," AARP (2018), *https://www.aarp.org/content/dam/aarp/ppi/2018/04/off-label-antipsychotic-use-in-older-adults-with-dementia.PDF.*

[57] *Id.*

[58] *Id.* at 2.

[59] Hannah Flamm, "Why Are Nursing Homes Drugging Dementia Patients Without Their Consent?", *Washington Post* (August 10, 2018), *https://www.washingtonpost.com/outlook/2018/08/10/8baff64a-9a63-11e88d5ec6c594024954_story.html?utm_term=.c17529d7c517.* This was an entirely anecdotal story where the author reports having "visited more than 100 nursing homes across six states" and extrapolates her conclusions from those visits. *Id.* Yet there are over 15,000 nursing homes nationwide. *See* "Fast Facts," American Health Care Association, *https://www.ahcancal.org/research_data/Pages/Fast-Facts.aspx* (last visited August 21, 2018). The federal measure for nursing home quality—the five-star system—also has the potential to mislead, as consumers will not be aware it grades on a curve. *See* Brendan Williams, "An Attack on New Hampshire Long-Term Care," *Concord Monitor* (2018) (it "requires no fewer than 20 percent of nursing homes in each state receive a one-star rating—and roughly 23.3 percent receive a two-star rating; only 10 percent can get the highest rating."). And because these assessments are state-specific, a one-star building in a high-quality state might be a five-star in a low quality state. *See id.*

[60] *See, e.g.,* Tonya Alanez and Erika Pesantes, "12 Nursing Home Deaths in Hollywood Ruled as Homicides," *Sun Sentinel* (November 22, 2017), *https://www.sun-sentinel.com/news/hollywood-nursing-home-hurricane-deaths/fl-sb-nursing-home-homicides-official-20171122-story.html.* There can be no excuse for resident neglect. Even if government funding is insufficient to support quality care, a responsible provider should close a facility, and not blame external forces. *See, e.g.,* Sabriya Rice and Holly K. Hacker, "Too Many Lawsuits or Bad Nursing Home Care? What's Behind Bankruptcy, Injuries, Deaths at Texas-Based Chain?", *Dallas Morning News* (January 25, 2018), *https://www.dallasnews.com/business/health-care/2018/01/25/preferred-care-texas-based-nursing-home-elder-neglect-injury-death-bankruptcy* ("A stream of documented complaints from three separate states flows back to one nursing home operator: Preferred Care of Plano, which filed for bankruptcy in November." As an excuse for alleged resident neglect, the company "cited more than 160 'predatory' lawsuits" and stated legal fees constrained "its ability to spend money on patient care.").

dents died at the small family-owned facility.[61] But, those who remember the tragedy may not think about all of the facilities where staff heroically saved their charges from harm in extreme conditions.[62] By contrast, few members of the public know of the alarming federal report to Congress, declaring that nursing homes nationally are effectively operating at a loss[63] because that finding appears to have generated no mainstream media coverage.

While critics challenge the nursing home sector nationally, it is better to get old and infirm in some states rather than in others. In Oklahoma, for example, one nursing home provider noted the reimbursement rate was $146 a day, or $134 if a provider tax was subtracted: "Clearly, $134 a day does not come close to covering the cost of round-the-clock room and board, let alone meeting payroll requirements for nursing staff. By comparison, Oklahoma state legislators receive a daily per-diem $156.50 when they are in session."[64] Whereas, the 2018 "basic" nursing home payment rate in Oregon, also the nation's leader in funding HCBS, was $312.87 per patient day.[65]

Underfunding in Oklahoma caused the 2018 closure of the Pawhuska Nursing Home, which had been "open for more than 60 years," displacing residents and staff from their rural community.[66] Oklahoma's nursing homes had reportedly "lost more than $93 million in state and federal appropriations since 2010."[67] During that time, Governor Mary Fallin responded to state budget woes by declaring an "Oilfield Prayer Day."[68] Cities in Oklahoma were looking to take over nursing homes as a gambit to increase facility reimbursement, as government-run facilities can draw

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[61] They will not know that the owners were acquitted of negligent homicide charges because they were not the real culprits. *See* Michael Dirda, "Book World: James A. Cobb Jr.'s 'Flood of Lies: The St. Rita's Nursing Home Tragedy'," *Washington Post* (October 16, 2013), *https://www.washingtonpost.com/entertainment/books/book-world-james-a-cobb-jrs-flood-of-lies-the-st-ritas-nursing-home-tragedy/2013/10/16/08952704-31bc-11e3-89ae16e186e117d8_story.html?utm_term=.1663aefc5dde* ("[T]he storm itself would have resulted in only a foot of flooding; the failure of the levees created the tremendous 10-foot deluge. And whose fault was that? The Army Corps of Engineers, which eventually admitted that the levees were poorly built and shoddily maintained."). That 45 people also died at a New Orleans hospital did not initiate an anti-hospital clamor. *See, e.g.,* Sheri Fink, "The Deadly Choices at Memorial," *New York Times* (August 25, 2009), *https://www.nytimes.com/2009/09/13/magazine/13letters-t-THEDEADLY CHO_LETTERS.html* ("Mortuary workers eventually carried 45 corpses from Memorial, more than from any comparable-size hospital in the drowned city."). According to the exhaustive *Times* article, "it appears that at least 17 patients were injected with morphine or the sedative midazolam, or both, after a long-awaited rescue effort was at last emptying the hospital." *Id.*

[62] In 2018, California nursing homes were forced to evacuate in the face of wildfires, as one article related:

> How do you evacuate a nursing home when the deadliest wildfire in California history is bearing down and there are 91 men and women to move to safety—patients in need of walkers or wheelchairs or confined to hospital beds, suffering from dementia, recovering from strokes?
>
> The fire is coming fast. Help is not.

Maria L. La Ganga, "California Fire: If You Stay, You're Dead. How a Paradise Nursing Home Evacuated," *Los Angeles Times* (November 17, 2018), *https://www.latimes.com/local/califomia/la-me-ln-nursing-home-fire-evac-20181117-story.html.*

[63] *See* Medicare Payment Advisory Commission, *supra* note 46.

[64] Tom Coble, "A Huge Fiscal Cliff Looms for Skilled Nursing," *McKnight's Long-Term Care News* (August 17, 2018), *https://www.mcknights.com/guest-columns/a-huge-fiscal-cliff-looms-for-skilled-nursing/article/788893/*. And maybe you get what you pay for. Oklahoma had among the nation's lowest-ranked nursing home care quality, according to one study. *See* Corey Jones, "AARP Report Provides Indicators of How Oklahoma Nursing Homes Are 'Failing to Provide Basic Levels of Care'," *Tulsa World* (September 4, 2018) (The head of the Oklahoma Association of Health Care Providers pointed out that "the reimbursement rate of $144.67 a resident per day in Fiscal Year 2017 was below the audited cost of $165.38, which was established by the Oklahoma Health Care Authority."). The payment shortfall, cited in the *Tulsa World* article, bears inexorably upon staff compensation, recruitment, and retention.

[65] *See* Letter from Oregon Department of Human Services to All Oregon Nursing Facilities (July 10, 2018), *https://www.oregon.gov/DHS/PROVIDERS-PARTNERS/LICENSING/AdminAlerts/1.%20NF%20Rate%20Letter%202018%20-%20Supplemental.pdf.*

[66] Jessica Remer, "Pawhuska Nursing Home Shuttering Due to State Budget Cuts," *KTUL. COM* (January 25, 2018), *https://ktul.com/news/local/pawhuska-nursing-home-shuttering-due-to-state-budget-cuts.*

[67] *Id.*

[68] Derek Hawkins, "Oklahoma Governor Mary Fallin Says All Faiths, Not Just Christians, Should Observe 'Oilfield Prayer Day'," *Washington Post* (Oct. 11, 2016), *https://www.washingtonpost.com/news/morning-mix/wp/2016/10/11/okla-gov-mary-fallin-says-all-faiths-not-just-christians-should-observe-oilfield-prayer-day/?utm_term=.41926d0ddcda.*

down more federal reimbursement.[69] In Indiana, "A wrinkle in Medicaid's complex funding formula gives Indiana nursing homes owned or leased by city or county governments a funding boost of 30 percent per Medicaid resident. The money is sent to the hospitals, which negotiate with the nursing homes over how to divvy it up."[70] One Pulaski County hospital alone acquired ten nursing homes statewide.[71]

All long-term care is subject to the vagaries of state budget decisions.[72] In Montana, one 2018 editorial noted that: "already rock bottom Medicaid reimbursement rates were lowered even more, leaving providers throughout the state in the impossible position of either cutting their Medicaid clients or continuing to serve them at a loss."[73]

Massachusetts is commonly known as a progressive state, yet one Massachusetts nursing home provider wrote a column noting that "financial data filed with the state's Center for Health Information and Analysis shows that all types of nursing facilities—family operated, not-for-profit, regional, and nationally owned—are teetering on the edge. How else would you describe a sector with more facilities operating on negative rather than positive margins?"[74] This nursing home provider's family has operated facilities in Massachusetts for 65 years.[75]

In its 2017 session, the Texas Legislature failed to adopt a common mechanism to improve federal Medicaid long-term care funding—a so-called "provider tax."[76] As one newspaper reported, "[t]he fee would raise an estimated $360 million over 2 years, going a long way toward bridging a gap in funding. The Medicaid match would increase that to an estimated $800 million."[77] In a 2017 column, the President of the Texas Health Care Association (the trade group representing Medicaid-contracting nursing homes) stated, "According to an analysis of the most recent available Medicaid cost report database, the average reportable cost per resident is $157 a day. The average reimbursement from the state for these same residents is just $138."[78]

Yet, Empower Texas, a conservative organization, opposed the Republican-sponsored bill, scoring it as anti-taxpayer and describing it as "[c]reating new hid-

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[69] *See* Paul Monies, "Cities Become Owners of Nursing Homes, Expecting Windfall from Feds," *Oklahoma Watch* (September 16, 2018), *https://oklahomawatch.org/2018/09/16/cities-become-owners-of-nursing-homes-expecting-windfall-from-feds/* (One city, with less than 6,300 residents, now owns 28 nursing homes around the state, and "[i]n all, licenses for 46 nursing homes are now owned by cities or towns"). Whether the federal government would approve this was a gamble.

[70] Phil Galewitz, "Chasing Millions in Medicaid Dollars, Hospitals Buy up Nursing Homes," *Washington Post* (October 13, 2017), *https://www.washingtonpost.com/business/economy/chasing-millions-in-medicaid-dollars-hospitals-buy-up-nursing-homes/2017/10/13/2be823ca-a943-11e7-92d1-58c702d2d975_story.html.* As these sorts of funding schemes are not replicable everywhere, they are just further evidence of the need for a federal fix to long-term care finances.

[71] *Id.*

[72] *See, e.g.,* Brendan Williams, "Do Right by All Medicaid Care Providers and Their Vulnerable Clients," *Nashua Telegraph* (January 10, 2019) ("If New Hampshire's nursing homes are to continue to be a vital safety net, the 17-cents-a-day Medicaid funding increase they received January 1st, for the over-4,000 residents whose care is state-funded, is not going to sustain them.").

[73] Editorial, "No Way to Run a State Budget," *The Missoulian* (August 5, 2018), *https://missoulian.com/opinion/editorial/no-way-to-run-a-state-budget/article_8916f59e-ab44-5137-bf5d-f2096d476b88.html.*

[74] Matt Salmon, "Nursing Home Sector on Verge of Collapse," *CommonWealth* (July 17, 2018), *https://commonwealthmagazine.org/opinion/nursing-home-sector-on-verge-of-collapse/; see also* Press Release, Massachusetts Senior Care Association, "Lawmakers Told Many Skilled Nursing Facilities on the Verge of Bankruptcy and Possible Closure" (September 11, 2017), *https://www.maseniorcare.org/about/newsroom/lawmakers-told-many-skilled-nursing-facilities-verge-bankruptcy-and-possible-closure* ("A recent analysis of 2016 state cost report data, filed with the Center for Health Information and Analysis (CHIA) shows three quarters of the state's nursing facilities have a combined negative margin of 4.4%, an indication that the sector is experiencing an unprecedented financial crisis.").

[75] *See* Salmon, *supra* note 75.

[76] Every state but Alaska has at least one provider tax. *See* "States and Medicaid Provider Taxes or Fees," Kaiser Family Foundation. (June 27, 2017), *https://www.kff.org/medicaid/fact-sheet/states-and-medicaid-provider-taxes-or-fees/* ("Provider taxes are imposed by states on health care services where the burden of the tax falls mostly on providers, such as a tax on inpatient hospital services or nursing facility beds. Provider taxes have become an integral source of financing for Medicaid.").

[77] Peggy Fikac, "Nursing Homes Joust Over Fee Proposal: 'Granny Tax' or Funding Lifeline?," *San Antonio Express-News* (March 27, 2017), *https://www.mysanantonio.com/news/local/article/Nursing-homes-joust-over-fee-proposal-Granny-11027904.php.*

[78] Kevin Warren, "Texas Nursing Homes Are at the Tipping Point," *Texas Tribune* (January 5, 2017), *https://www.tribtalk.org/2017/01/05/texas-nursing-homes-are-at-the-tipping-point/.*

den fee[s] on residents of nursing home facilities."[79] It passed in the Republican House, 96–43, before dying in the Senate.[80]

After the Texas Legislature failed to improve nursing home rates, Genesis HealthCare, one of the nation's largest nursing home providers, announced it would sell all 23 of its Texas facilities to a real estate investment trust (REIT).[81] In 2018, the largest nursing home provider in Texas, with over one hundred facilities, declared bankruptcy.[82]

REITs are common owners of nursing facilities, though not the state bed licenses, and the rent pressures that the care providers face do not always operate in the best interests of care.[83] This creates fights between the facility operators and landlords.[84] Genesis, operating more than 450 facilities nationwide, had threatened bankruptcy before announcing, in February 2018, that it "negotiated $54 million worth of annual lease reductions that are effective retroactively to January 1st. The move will cut the company's rent fees by 11 percent, when compared to 2017."[85] Also, in 2018, a joint venture saved HCR ManorCare, which operated around 500 long-term care facilities nationwide, from Chapter 11 bankruptcy by purchasing both ManorCare and the REIT that had owned its facilities.[86] As one article noted, "Former ManorCare landlord Quality Care Properties had been locked in an extended battle with its tenant over missed rent payments, which eventually sent ManorCare into Chapter 11 bankruptcy protection."[87] Illustrating the nursing home sector's precariousness, the acquiring company saw its bond rating downgraded significantly.[88]

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[79] *See* HB 2766: Creating New Hidden Fee on Residents of Nursing Home Facilities, EmpowerTexans, *https://index.empowertexans.com/votes/2017-house-vote-rv1141* (last visited August 20, 2018).

[80] *See id.*

[81] John George, "Genesis Selling Off 2 Dozen Skilled Nursing Facilities in Texas," *Philadelphia Business Journal* (2018).

[82] *See* Holly K. Hacker and Sue Ambrose, "Texas' Largest Nursing Home Operator Files for Bankruptcy, Sparking Concerns About Patients, Jobs," *Dallas Morning News* (December 5, 2018), *https://www.dallasnews.com/business/business/2018/12/05/texas-largest-nursing-home-operatorfiles-bankruptcy-sparking-concems-patients-jobs.*

[83] *See* Peter Whoriskey and Dan Keating, "Overdoses, Bedsores, Broken Bones: What Happened When a Private-Equity Firm Sought to Care for Society's Most Vulnerable," *Washington Post* (November 25, 2018) (After selling its properties to a real estate investment company, "HCR ManorCare had to make massive rent payments to its new landlord, and these, according to the company's accounting, raised the company's long-term financial obligations to $6 billion.").

[84] *See* Alex Spanko, "REITs Adopt Novel Approaches to Stay Relevant in Skilled Nursing," *Skilled Nursing News* (June 3, 2018) (noting that "publicly traded REITs also played some role in the difficulties facing individual skilled nursing operators: In a world of changing reimbursements, staffing pressures, and regulatory scrutiny, the skilled nursing model has become increasingly difficult to reconcile with annual rent escalators and quarterly scrutiny from shareholders.").

[85] George, *supra* note 82.

[86] Jon Chavez, "ProMedica, Welltower, Finalize Purchase of HCR ManorCare, *Toledo Blade* (July 27, 2018), *https://www.toledoblade.com/business/2018/07/26/ProMedica-Welltower-finalize-purchase-of-HCR-ManorCare/stories/20180726203.*

[87] Alex Spanko, "S&P Downgrades ProMedica in Wake of ManorCare-Welltower Deal," *Skilled Nursing News* (August 15, 2018), *https://skillednursingnews.com/2018/08/sp-downgrades-promedica-wake-manorcare-welltower-deal/*. A threat to simply turn over the keys can be an effective negotiating tactic, as a REIT is unlikely to have any more success turning a profit than its provider tenant, and would not want empty buildings in its portfolio. That is effectively what HCR ManorCare did. *See* Tara Bannow, "HCR ManorCare Files for Bankruptcy, Proposes Ownership Transfer," *Modern Healthcare* (March 5, 2018), *https://www.modernhealthcare.com/article/20180305/NEWS/180309949* ("Struggling nursing home provider HCR ManorCare's parent company filed for bankruptcy Sunday, and plans to shift ownership and leadership to its landlord, the real estate investment trust Quality Care Properties.").

[88] *See* Spanko, *supra* note 88 ("The Toledo, Ohio-based hospital and skilled nursing chain now sits at BBB, down from the A+ rating ProMedica had maintained ahead of its blockbuster deal to acquire struggling nursing chain HCR ManorCare."). More consolidation under REIT ownership is likely to occur under a new Medicare payment model. *See* Maggie Flynn, "PDPM Piles the Pressure on Smaller Skilled Nursing Operators," *Skilled Nursing News* (August 27, 2018), *https://skillednursingnews.com/2018/08/pdpm-piles-pressure-smaller-skilled-nursing-operators/* (Some are predicting "a wave of skilled nursing sales by smaller, mom-and-pop style operators."). Consolidation can bring efficiencies of scale. It can, however, also bring operators who are not proficient at care, with systemic, as opposed to individual, facility failures. *See, e.g.,* Whoriskey and Keating, *supra* note 84 ("Under the ownership of the Carlyle Group, one of the richest private-equity firms in the world, the ManorCare nursing-home chain struggled financially until it filed for bankruptcy in March."); Kay Lazar, "Troubled Massachusetts Nursing Home Chain in 'Dire' Straits," *Boston Globe* (September 1, 2018), *https://www.bostonglobe.com/*

Continued

In 2017, Kindred Healthcare—once one of the nation's largest nursing home companies—sold all of its nursing homes.[89] Four that subsequently closed were located in Massachusetts.[90]

As was true for the small Pawhuska Nursing Home in rural Oklahoma, state funding pressures have not been limited to large, profit-oriented chains. In Illinois, for example, a 113-year-old, 98-bed nursing home closed in 2018 due to state inefficiency in processing Medicaid payments.[91] As the *State Journal-Register* reported:

> For Pleasant Hill, a not-for-profit facility associated with the Church of the Brethren, waiting on $2.3 million in Medicaid payments for residents whose applications remain pending—some as long as two to 3 years and some involving people who have died during the wait—has become too much of a burden.[92]

The delayed payments amounted to "44 percent of the nursing home's annual spending."[93]

Citing inadequate Medicaid payments that caused it to lose over $1 million annually, a 45-year-old nonprofit nursing home in New Hampshire closed its doors in 2016.[94] This is particularly troubling considering New Hampshire has the nation's second-oldest median age.[95] In 2018, the president and CEO of Catholic Charities New Hampshire wrote that "our 800 nursing home employees serve approximately 1,000 residents; of those, 60 to 78 percent are on Medicaid. Historically, we operate on a 1.5 to 2.5 percent margin. But last year we had a negative margin."[96]

Nursing home providers in seemingly-progressive states are not immune from funding pressures. After winning a $24 million Medicaid recovery lawsuit, nursing homes in Rhode Island were threatened with the retribution of an 8.5 percent state budget cut in 2018, so they settled the lawsuit and instead agreed to "a 1.5 percent increase on July 1, and another 1 percent in October."[97]

A 2017 RAND Corporation study found that "[a]mong persons age 57 to 61, 56 percent will stay in a nursing home at least one night during their lifetime."[98] Michael Hurd, the study's lead author, noted that due to the unviability of long-term care insurance, "people should be prepared to use the societally provided insurance, which is Medicaid."[99]

But, will the facilities be there for them? According to one 2018 report, "The 31 largest metropolitan markets have 13,586 fewer nursing home beds now than in late

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metro/2018/08/31/troubled-massachusetts-nursing-home-chain-dire-straits-court-monitor-warns/WtywMujnoo7Fy2qYdlvdxL/story.html ("With the company's finances deteriorating, eight Synergy facilities have been placed into the hands of a court-appointed receiver, which is trying to untangle a labyrinth of unpaid bills for everything from medicine and food to cleaning services, court records show.").

[89] *See, e.g.,* Marty Stempniak, "Kindred Shareholders Approve Sale to Humana," *McKnight's Long-Term Care News* (April 6, 2018), *https://www.mcknights.com/news/kindred-shareholders-approve-sale-to-humana/*.

[90] Shira Schoenberg, "Kindred Healthcare, Heritage Nursing to Collectively Close Five Massachusetts Nursing Homes, Leaving 600 to Find New Place to Live," MassLive (December 5, 2017), *https://www.masslive.com/politics/index.ssf/2017/12/five_massachusetts_nursing_hom.html.*

[91] *See* Dean Olsen, "Medicaid Processing Backlog a Fatal Blow for Girard Nursing Home," *State Journal-Register* (July 9, 2018), *https://www.sj-r.com/news/20180706/medicaid-processing-backlog-fatal-blow-for-girard-nursing-home.*

[92] *Id.*

[93] *Id.*

[94] John P. Gregg, "Clough Center To Close," *Valley News* (June 16, 2016), *https://www.vnews.com/New-London-Hospital-to-Close-Clough-Nursing-Home-2888282.*

[95] *See* Press Release, U.S. Census Bureau, The Nation's Older Population Is Still Growing, Census Bureau Reports (June 22, 2017) (noting that, nationally, "Residents age 65 and over grew from 35.0 million in 2000, to 49.2 million in 2016, accounting for 12.4 percent and 15.2 percent of the total population, respectively.").

[96] Thomas E. Blonski, "A Troubling Future for New Hampshire's Elderly?", *Concord Monitor* (March 1, 2018), *https://www.concordmonitor.com/A-troubling-future-for-NH-elderly-15824078* (even charities cannot long afford to operate at a loss.).

[97] Katherine Gregg, "State, Nursing Homes Reach Potential Settlement in Medicaid Lawsuit," *Providence Journal* (June 12, 2018), *https://www.providencejournal.com/news/20180612/state-nursing-homes-reach-potential-settlement-in-medicaid-lawsuit.*

[98] Press Release, RAND Corp., "Average American's Risk of Needing Nursing Home Care is Higher Than Previously Estimated" (August 28, 2017), *https://www.rand.org/news/press/2017/08/28/index1.html.*

[99] *Id.*

2005."[100] Some states are trying to do better. In Maine and Massachusetts, in 2018, lawmakers voted to dramatically increase nursing home funding to afford better wages for caregivers.[101] In Maine, legislators even overcame a gubernatorial veto.[102] Following her 2018 re-election, Oregon Governor Kate Brown, a Democrat, proposed a ten percent Medicaid funding increase for long-term care facilities.[103] These are very positive efforts. However, they not only accentuate the disparate treatment of nursing home care by states, but they may not be sustainable in the event of an economic downturn—when Medicaid is often on the chopping block. In other words, a *federal* funding strategy is still needed.

B. Assisted Living Facilities

According to the National Center for Assisted Living, "There are 30,200 assisted living communities with 1 million licensed beds in the United States today."[104]

Oregon was the first state, in 1981, to apply for a federal waiver to serve Medicaid beneficiaries in long-term care settings other than nursing homes, and it is credited with having the first assisted living facility.[105] An *Oregonian* article identified the "trade-offs" of assisted living: "It's less regulated than nursing homes, which lets residents be more independent about where they move and what they do. But there's also less safety regulation and checks that people are having good health outcomes."[106]

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[100] Paula Span, "In the Nursing Home, Empty Beds and Quiet Halls," *New York Times* (September 28, 2018), *https://www.nytimes.com/2018/09/28/health/nursing-homes-occupancy.html*. As the story notes:

> For more than 40 years, Morningside Ministries operated a nursing home in San Antonio, caring for as many as 113 elderly residents. The facility, called Chandler Estate, added a small independent living building in the 1980s and an even smaller assisted living center in the 1990s, all on the same four-acre campus.The whole complex stands empty now.

Id.

[101] *See* Brendan Williams, "NH Needs to Invest in Care for Seniors," *Portsmouth Herald* (July 11, 2018), *https://www.seacoastonline.com/news/20180711/nh-needs-to-invest-in-care-for-seniors*. In Massachusetts, the Legislature adopted a budget specifying that "not less than $38,300,000 shall be expended to fund a rate add-on for wages, shift differentials, bonuses, benefits and related employee costs paid to direct care staff of nursing homes; provided further, that MassHealth regulations for this rate add-on shall prioritize spending on hourly wage increases, shift differentials or bonuses paid to certified nurses' aides and housekeeping, laundry, dietary and activities staff[.]" *See* 2018 Mass. Acts ch. 154 § 4000–0641.

[102] *See* Mal Leary, "LePage Vetoes More than 20 Bills, Including Funding for Prison and Direct Care Workers," *Maine Pubic* (July 2, 2018), *http://www.mainepublic.org/post/lepage-vetoes-more-20-bills-including-funding-prison-and-direct-care-workers*. The Maine legislators approved provided one-time additional funding for wage increases for workers in long-term care facilities of "[a]n amount equal to 10% of allowable wages and associated benefits and taxes. . . ." 2018 Me. Laws ch. 460 § B–3(1), *http://www.mainelegislature.org/legis/bills/getPDF.asp?paper=HP0653&item=3&snum=128*. Going forward, the law also provides "an inflation adjustment for a cost-of-living percentage change in nursing facility reimbursement each year in accordance with the United States Department of Labor, Bureau of Labor Statistics Consumer Price Index medical care services index." *Id.* at § B–1. And yet even Maine, with the nation's oldest population, saw a record number of nursing home closures in 2018. *See* Jackie Farwell, "Record Number of Maine Nursing Homes Closed This Year, Displacing Hundreds," *Bangor Daily News* (December 12, 2018), *https://bangordailynews.com/2018/12/12/mainefocus/record-number-of-maine-nursing-homes-closed-this-year-displacing-hundreds/* ("The personal toll of the closures on the elderly and their families is acute, said Trish Thorsen, program manager for the Maine Long-Term Care Ombudsman Program, which advocates for nursing home residents."). Rural facilities are particularly vulnerable. *See id.* In South Dakota, it was reported in December 2018 that "[t]he health and stability of some of South Dakota's most vulnerable residents are being threatened by a wave of closures of long-term care facilities across the state." Bart Pfankuch, "Wave of Nursing Home Closures Hitting Small South Dakota Communities," *South Dakota News Watch* (December 12, 2018), *https://www.sdnewswatch.org/stories/wave-of-nursing-home-closures-hitting-small-south-dakota-communities/* ("Nursing homes are sometimes the biggest employer in small towns and employees are typically laid off upon closure. Residents of rural nursing homes tend to be locals and uprooting them from their long-term homes is physically and emotionally traumatic for the patients and their loved ones.").

[103] *See* Hillary Borrud, "Top Takeaways from Governor Kate Brown's $23.6 Billion Budget Proposal," *Oregonian* (November 29, 2018), *https://www.oregonlive.com/politics/2018/11/top-takeaways-from-gov-kate-browns-236-billion-budget-proposal.html*.

[104] *See* National Center for Assisted Living, *https://www.ahcancal.org/ncal/facts/Pages/Communities.aspx* (last visited March 4, 2019).

[105] *See* Lynne Terry, "Winners and Losers as Oregon's Population Ages," *Oregon Business* (July 9, 2018), *https://www.oregonbusiness.com/article/real-estate/item/18395-boomer-s-future*.

[106] *See* Andy Dworkin, "Oregon Among National Leaders in Number of Assisted Living Facilities," *Oregonian* (January 5, 2010), *https://www.oregonlive.com/news/index.ssf/2010/01/oregon_among_national_leaders.html*.

The growth of the sector can lead to challenges. In 2014, Brookdale Senior Living acquired Emeritus Corporation for $2.8 billion, expanding its footprint to 1,100 assisted living facilities.[107] In August 2018, amidst news that Brookdale was selling 27 facilities, its stock had reportedly fallen to $8.19 per share from over $38 per share in 2015.[108] Brookdale was not reported at risk of insolvency,[109] but its challenges as a sector leader show that in long-term care, the expression "[i]f you build it, he will come"[110] is not a guaranteed business proposition.[111]

Unlike nursing homes, assisted living facilities may find it possible, even preferable, to operate without Medicaid contracts.[112] Since this does not allow residents to age-in-place upon spending down their resources, it can lead to some troubling stories:

> Assisted Living Concepts Inc. drew attention within its first year as a public company when it began forcing people such as Gladys Dixon, nearly blind and a few days shy of 103 years old, to leave its assisted living centers.
>
> Dixon was among those whose care was paid for by Medicaid, which pays much lower rates than other residents pay. At the time, Assisted Living Concepts, which went public in 2006, planned to increase profits by accepting only so-called private-pay residents.[113]

Yet there can be no requirement that facilities take residents that cause them to operate at a loss. In New York City, for example, the Medicaid assisted living payment can be as low as $75.85 per day.[114]

In those cases where there *are* Medicaid residents, there has been publicity as to what the federal government gets in exchange for Medicaid payments to assisted living facilities, given the patchwork of state regulations and laws.[115] In 2018, *The New York Times* reported, "Federal investigators say they have found huge gaps in the regulation of assisted living facilities, a shortfall that they say has potentially jeopardized the care of hundreds of thousands of people served by the booming industry."[116] The article also noted that "[s]tates reported spending more than $10 billion a year in federal and state funds for assisted living services for more than 330,000 Medicaid beneficiaries, an average of more than $30,000 a person, the Government Accountability Office found in a survey of states."[117]

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[107] Eleanor Kennedy, "$2.8-billion Brookdale-Emeritus Merger Closes," *Nashville Business Journal* (July 31, 2014), *https://www.bizjournals.com/nashville/blog/health-care/2014/07/2-8-billion-brookdale-emeritus-merger-closes.html.*

[108] John Stinnett, "Brookdale's CEO on What's Fueling the Sale of 28 Facilities," *Nashville Business Journal* (August 20, 2018), *https://www.bizjournals.com/nashville/news/2018/08/20/brookdales-ceo-on-whats-fueling-the-sale-of-28.html.*

[109] Instead, some investors have pressed the company to sell some of its valuable real estate. *See* Joel Stinnett, "Activist Investor Renews Criticism of Brookdale Senior Living," *Nashville Business Journal* (August 10, 2018), *https://www.bizjournals.com/nashville/news/2018/08/10/activist-investor-renews-criticism-of-brookdale.html.*

[110] *See* "Field of Dreams Quotes," IMDB, *https://www.imdb.com/title/tt0097351/quotes* (last visited Jan. 25, 2018).

[111] Building booms can lead to overcapacity bubbles, which is why nursing home providers tend to favor certificate of need and bed moratorium laws. In New Hampshire, one assisted living facility declared bankruptcy with a "$16.6 million debt and losing money daily." *See* Bob Sanders, "Financial Woes Threaten Seacoast Assisted Living Facility," *New Hampshire Business Review* (May 2, 2017), *https://www.nhbr.com/May-12-2017/Financial-woes-threaten-Seacoast-assisted-living-facility/.*

[112] In Arkansas, for example, assisted living facilities faced a possible 22% Medicaid cut going into 2019. *See* Andy Davis, "Proposal to Cut Aid for Elderly, Disabled Pulled; State Officials Will Study Plan for 8,800 ARChoices Clients," *Arkansas Democrat Gazette* (December 19, 2018), *https://www.arkansasonline.com/news/2018/dec/19/proposal-to-cut-aid-for-elderly-disable-1/.*

[113] Guy Boulton, "Assisted Living Concepts Purchase Completed," *Milwaukee-Wisconsin Journal Sentinel* (July 13, 2013), *http://archive.jsonline.com/business/assisted-living-concepts-purchase-completed-b9953271z1-215347351.html.*

[114] *See* "January 1, 2018 Assisted Living Program Minimum Wage Rate Schedule," New York Department of Health (April 2018), *https://www.health.ny.gov/facilities/long_term_care/reimbursement/alp/2018-01-01_alp_min_wage_rates.htm* (Schedule for "PA = REDUCED PHYSICAL FUNCTIONING A"). A similarly-classed resident's care would only be worth $44.33 a day to the state in upstate rural New York. *Id.*

[115] Robert Pear, "U.S. Pays Billions for 'Assisted Living,' but What Does It Get?", *New York Times* (February 3, 2018), *https://www.nytimes.com/2018/02/03/us/politics/assisted-living-gaps.html.*

[116] *Id.*

[117] *Id.*

Yet there was far less to that General Accountability Office (GAO) report than media accounts, as it was based upon 2014 data and involved an admittedly "non-generalizable sample of three states: Georgia, Nebraska, and Wisconsin."[118] In 2014, a new CMS rule was adopted, requiring greater reporting by states.[119] CMS needs to enforce that expectation. The GAO found that even accessing Medicaid assisted living was a challenge, reporting common factors that states identified:

> (1) [T]he number of assisted living facilities willing to accept Medicaid beneficiaries (13 states or 27 percent of the 48 states);
>
> (2) program enrollment caps (9 states or 19 percent of the 48 states);
>
> (3) beneficiaries' inability to pay for assisted living facility room and board (9 states or 19 percent of the 48 states), which Medicaid typically does not cover; and
>
> (4) low rates the state Medicaid program paid assisted living facilities (8 states or 17 percent of the 48 states).[120]

Given the cost of the federal regulatory regime that applies to nursing homes, assisted living should remain state-regulated. Too often in long-term care, the impetus for regulation is driven by the outlier as opposed to an empirical basis.[121] States are getting the benefit of their bargain, such as New Hampshire, where 24/7 care, meals, and housing in an assisted living facility cost the state a daily Medicaid rate of just $50.96.[122] That is less than the cost of a cheap motel.[123]

Moreover, the scope of care that assisted living facilities can provide varies widely by state. In Washington, where the licensure of such facilities dates to 1957, facilities may not admit, or retain, "any aged person requiring nursing or medical care of a type provided by" a nursing home, except when registered nurses are available, and upon a doctor's order that a supervised medication service is needed, it may be provided. Whereas, under California law:

> The Legislature hereby finds and declares that in order to protect the health and safety of elders in care at residential care facilities for the elderly, appropriate oversight and regulation of residential care facilities for the elderly requires regular, periodic inspections of these facilities in addition to investigations in response to complaints. It is the intent of the Legislature to increase the frequency of unannounced inspections.[124]

In Texas, "inspection and survey personnel will perform inspections and surveys, follow-up visits, complaint investigations, investigations of abuse or neglect, and other contact visits from time to time as they deem appropriate or as required for carrying out the responsibilities of licensing."[125]

These types of oversight standards should be adopted in all states. Yet oversight alone will not be enough to make assisted living a reliable option for Medicaid beneficiaries—only funding can accomplish this goal. Policymakers who are only focused on nursing home care and home care may overlook assisted living, which provides a social atmosphere in a residential setting.

Some states may have more exotic, small facility-based care options that are beyond the reach of this article. In Washington State, adult family homes have been described as "a growing, lightly regulated housing option for the state's aged and

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[118] *See* U.S. Government Accountability Office, GAO–18–179, "Medicaid Assisted Living Services: Improved Federal Oversight of Beneficiary Health and Welfare is Needed" 5 (2018).

[119] *See* Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers, 79 Fed. Reg. 2947, 2969 (January 16, 2014) ("While we are not changing the existing quality assurances through this rule, we clarified that states must continue to assure health and welfare of all participants when target groups are combined under one waiver, and assure that they have the mechanisms in place to demonstrate compliance with that assurance.").

[120] U.S. Government Accountability Office, *supra* note 122, at 40.

[121] The prevalence of staph infections, like methicillin-resistant Staphylococcus aureus (MRSA), have not led to a strict, overarching federal regulatory regime for hospitals—just Medicare reimbursement penalties. *See, e.g.,* Anthony Sannazzaro, "MRSA: The Superbug Poised to Cost Hospitals Super Sums," *Infection Control Today* (December 29, 2015), *https://www.infectioncontroltoday.com/bacterial/mrsa-superbug-poised-cost-hospitals-super-sums.*

[122] *See* Williams, *supra* note 102 ("At least one Portsmouth dog-sitting service charges more overnight than the $50.96 the state is willing to reimburse for assisted living care.").

[123] *Id.*

[124] California Health and Safety Code § 1569.331 (2018).

[125] Texas Administrative Code § 92.81 (2018).

frail. DSHS licenses residential homeowners to rent out bedrooms and provide care for up to six residents."[126] In 2010, there was a move to increase their licensure fee tenfold, from $100 per bed annually to $1,000, so that, like assisted living facilities and nursing homes, adult family homes would pay for oversight.[127] The impetus behind this movement came partly from a *Seattle Times* investigation that "uncovered myriad accounts of inadequately trained caregivers who imprisoned the elderly in their rooms, roped residents into beds at night and drugged others into submission."[128] The providers successfully resisted any increase in licensure fees.[129] Eight years later, the fee, at $225 per bed through June 30, 2020,[130] falls far short of the regulatory cost identified in 2010.[131] This is the only class of facility-based care providers in the United States that collectively bargain with a state as if unionized.[132]

C. Home Care

According to the AARP's 2018 Home and Community Preferences Survey, more than 70% of those 50-and-older would prefer to remain in their communities and in their personal residences.[133]

In-home care offers these promises to those whose physical or mental impairment does not require facility-based care.[134] Oregon law, for example, requires the state to make health and social services available that "[a]llow the older citizen and citizen with a disability to live independently at home or with others as long as the citizen desires without requiring inappropriate or premature institutionalization."[135]

The Paraprofessional Healthcare Institute (PHI) reports that there are "over 2 million home care workers" as compared to "600,000 nursing assistants employed in nursing homes. . . ."[136] PMI estimates that between 2016 and 2026, home care will add over 1 million jobs, "which represents the largest growth of any job sector in the country."[137]

Although, this is a challenged workforce. As of 2018, the median wage was $11.03 per hour.[138] Accordingly, that report found that "[o]ne in five home care workers lives below the federal poverty line (FPL) and over half rely on some form of public assistance."[139] Almost 90 percent are women, and 30 percent are immigrants.[140]

The New York Times noted, "providing care for older people, in their homes or in facilities, has become the classic example of a job native-born Americans would rather not take."[141] Thus, immigration restrictions threaten to make things worse.[142] A 2017 *Politico* article warned that "[o]ne of the biggest future crises in U.S. health care is about to collide with the hottest political issue of the Trump era: immigration."[143] The article noted that "[t]here's a reason foreign-born workers take so

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[126] Michael J. Berens, "Adult-Home Owners Avoid Big Fee Increase," *Seattle Times* (April 8, 2015), *https://www.seattletimes.com/seattle-news/special-reports/adult-home-owners-avoid-big-fee-increase/*.

[127] *See id.*

[128] *Id.*

[129] *Id.*

[130] 2018 Wash. Sess. Laws ch. 299 § 205(b)(i). A question with such very small-scale facilities is whether mandatory reporting of abuse or neglect will actually occur; *i.e.,* will Mom blow the whistle on Pop?

[131] *See* Berens, *supra* note 131.

[132] *See* Wash. Rev. Code § 41.56.029(1) (2018) ("Solely for the purposes of collective bargaining . . . the governor is the public employer of adult family home providers who, solely for the purposes of collective bargaining, are public employees.").

[133] Joanne Binette and Kerri Vasold, "2018 Home and Community Preferences: A National Survey of Adults Age 18-Plus," AARP (August 2018), *https://www.aarp.org/research/topics/community/info-2018/2018-home-community-preference.html.*

[134] *See, e.g.,* "What Is the Difference Between In-Home Care and Home Health Care?", *Winston-Salem Journal* (December 31, 2018) ("You might consider hiring in-home care if you or a loved one needs assistance with activities of daily living, does not drive or have access to transportation or live alone and are at risk for social isolation.").

[135] Or. Rev. Stat. § 10.020(3)(a)(2018).

[136] "Understanding the Direct Care Workforce," PHI, *https://phinational.org/policy-research/key-facts-faq/* (last visited December 4, 2018).

[137] *Id.*

[138] Campbell, *supra* note 46 at 2.

[139] *Id.*

[140] *Id.* at 3.

[141] Paula Span, "If Immigrants Are Pushed Out, Who Will Care for the Elderly?", *New York Times* (February 2, 2018), *https://www.nytimes.com/2018/02/02/health/illegal-immigrants-caregivers.html.*

[142] *See id.*

[143] Ted Hesson, "Why Baby Roomers Need Immigrants," *Politico* (October 25, 2017), *https://www.politico.com/agenda/story/2017/10/25/immigrants-caretaker-workforce-000556.*

many home health jobs: they're low-paid, low-skilled and increasingly plentiful. Barriers to entry are low; a high school degree is not usually a requirement and neither is previous work experience."[144] Yet, "[o]ther low-wage workplaces (McDonald's, for instance) offer much better benefits, even tuition reimbursement[.]"[145]

Not only is our future home care workforce at risk, but our current workforce is as well. According to a 2018 *Washington Post* article, 59,000 Haitians live in the United States under temporary protected status (TPS), a humanitarian program that has given them permission to live and work in this country since the earthquake. Many are nursing assistants, home health aides and personal care attendants—the trio of jobs that often defines direct-care workers.[146] PHI estimated that the direct care workforce also included 69,800 "non-U.S. citizens from Mexico."[147]

Today all of these workers face the real prospect of deportation. The *Post* reported:

> The Trump administration's immigration restrictions may exacerbate a serious shortage of direct-care workers, warns Paul Osterman, a professor at the Massachusetts Institute of Technology's Sloan School of Management. He forecasts a national shortfall of 151,000 workers by 2030 and of 355,000 workers by 2040. If immigrants lose their work permits, the gap would widen further.[148]

Indeed, the number of immigrant caregivers might be higher than reported, as *The New York Times* noted: "In the so-called gray market, where consumers hire home care workers directly and often pay them under the table, the proportion is likely far higher."[149]

What is the alternative for those desperate for care? Gone are the days of parents expecting their children to provide care. *The Minneapolis Star Tribune* reported, "Family sizes have been shrinking for decades, which means there will be fewer adults to care for older relatives in the years ahead. By 2030, the ratio of informal caregivers to those in most need of care will be at 4 to 1, down from a peak of 7 to 1 in 2010."[150] The article further noted, "Family caregivers have been described as America's other Social Security. The nation's health system would go broke if it had to pay for their work, valued at $470 billion a year in free care, according to AARP."[151]

Standards for home care can vary widely. Per citizen's initiative, Washington State requires the most hours of "entry-level training" (75 hours) for those providing home care to non-family members.[152] However, Washington is also on a path to provide living wages to home care workers. Under their union contract with the state, each Medicaid home care worker (or "individual provider") makes no less than $15 an hour and receives health care benefits.[153]

By contrast, Missouri cut $50 million from in-home care in 2017.[154] "[A]t least 7,844 disabled Missourians" were at risk, according to the House Budget chair.[155] And it was not as if home care in Missouri was prospering before. In 2016, Republican legislators overrode a gubernatorial veto and, through legislation, rejected the

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[144] *Id.*
[145] *Id.*
[146] Melissa Bailey, "As Trump Targets Immigrants, Elderly and Others Brace to Lose Caregivers," *Washington Post* (March 24, 2018), *https://www.washingtonpost.com/national/health-science/as-trump-targets-immigrants-elderly-and-others-brace-to-lose-caregivers/2018/03/24/72d5a0d0-2d3e-11e8-8ad6-fbc50284fcstory.html?utm_term=.828236b697.*
[147] *Id.*
[148] *Id.*
[149] Span, *supra* note 147.
[150] Jackie Crosby, "'Invisible Workforce' of Caregivers Is Wearing Out as Boomers Age," *Minneapolis Star Tribune* (June 3, 2018), *http://www.startribune.com/invisible-workforce-of-caregivers-is-wearing-out/483250981/.*
[151] *Id.*
[152] Wash. Rev. Code § 74.39A.074(1)(b).
[153] *See* "Collective Bargaining Agreement, State of Washington and Service Employees International Union" 775, 2017–2019 (2017), *http://seiu775.org/files/2017/09/Homecare17_19 WebReady-signature-page-w-mou.pdf.*
[154] Samantha Liss, "After Missouri Cuts Funding for the Disabled, Some Fear They May Be Forced into Nursing Homes," *St. Louis Post-Dispatch* (August 16, 2018), *https://www.stltoday.com/news/local/govt-and-politics/after-missouri-cuts-funding-for-the-disabled-some-fear-they/article_76b2dac9-76ed-5545-9689-e87650d4a3ab.html.*
[155] *Id.*

governor's plan to raise Medicaid home care workers' wages to between $8.50 and $10.15 per hour.[156]

Too often, the plight of home care workers is invisible. Ai-jen Poo, executive director of the National Domestic Workers Alliance, stated:

> This is a workforce where the private home is their workplace. So you could go into any neighborhood or apartment building and not know which of these homes are also workplaces. There's no list anywhere. They're not registered anywhere. There's no other coworkers. You're mostly isolated and alone. And there's certainly no HR department or anything like that.[157]

This invisibility, coupled with the fact that the workforce is predominantly nonwhite women,[158] caring for an elderly population that is largely women, cannot be factored out in explaining home care's funding neglect.[159]

III. CONCLUSION

As U.S. Rep. Debbie Dingell (D–MI) has explained, those contemplating long-term care will often "encounter a fragmented system with multiple programs intended to support their needs and the needs of their loved ones, each of which has its own complicated rules and regulations."[160] She noted that "[t]he average American may think Medicare provides for long-term care," but the reality is that it covers very little.[161]

In Maine, the Senate Democratic leader who pushed for higher wages for nursing home workers stated, "In Maine, we talk a lot about taking care of our seniors but words only go so far."[162] He could have been referring to the nation as a whole.

Rather than have long-term care providers in the states ride a roller coaster of funding uncertainty, lurching from one existential crisis to the next, it makes more sense for the federal government to have a funding strategy that recognizes Medicaid has become de facto long-term care insurance.[163]

The Commission on Long-Term Care reported in 2013 that "[e]xpanded market penetration of private LTC insurance has been limited by the cost of coverage and medical underwriting, and is further hampered today by insurers reassessing the

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[156] Jack Suntrup, "Home Health Care Workers Likely Won't See Raise After Lawmakers Override Nixon Veto," *St. Louis Post-Dispatch* (May 3, 2016), *https://www.stltoday.com/news/local/govt-and-politics/home-health-care-workers-likely-won-t-see-raise-after/article_db94402f-0ee6-5405-9fe4-7717616a2de6.html.*

[157] Ivette Feliciano and Corinne Segal, "'You're Mostly Isolated and Alone.' Why Some Domestic Workers Are Vulnerable to Exploitation," PBS (August 12, 2018), *https://www.pbs.org/newshour/nation/ai-jen-poo-domestic-workers-exploitation.*

[158] *See* Campbell, *supra* note 46 at 3 (only 40% of home care workers are white). The roots of U.S. home care trace back to slavery, as one scholar notes. *See* Rebecca Donovan, "Home Care Work: A Legacy of Slavery in U.S. Health Care," *Affilia* at 33–44 (September 1, 1987) ("The specific job tasks of the home attendant or home health aide (shopping, cleaning, and cooking) are the same household tasks once performed by black women as slaves and later as domestic servants in private households.").

[159] The Trump Administration is making it harder for home care workers to organize into unions. *See, e.g.,* Michael Hiltzik, "Targeting Home Healthcare Workers, the Trump Administration Opens Another Front in its War on Public Employees," *Los Angeles Times* (July 30, 2018), *https://www.latimes.com/business/hiltzik/la-fi-hiltzik-home-health-20180730-story.html* ("Medicaid authorities have launched a new attack on unions serving home healthcare workers . . . aimed transparently at depriving their unions of financial resources.").

[160] Debbie Dingell, "Aging with Dignity Out of Reach for Many in America," *Detroit Free Press* (July 11, 2015), *https://www.freep.com/story/opinion/contributors/2015/07/10/retirement-long-term-care/29998343/.*

[161] *Id.; see* "Skilled Nursing Facility (SNF) Care," *Medicare.gov, https://www.medicare.gov/coverage/skilled-nursing-facility-care.html* (last visited March 4, 2019) (If you meet "the 3-day inpatient hospital stay requirement" and are discharged from a hospital, Medicare will cover a nursing home stay for up to 100 days—paying in full for 20 days, and in part for up to 80 days thereafter.).

[162] Press Release, Me. Sen. Troy Jackson, Budget Committee Unanimously Votes to Fund Jackson Nursing Home Bill (June 12, 2018), *http://www.mainesenate.org/budget-committee-unanimously-votes-to-fund-jackson-nursing-home-bill/.*

[163] *See* 42 U.S.C. § 1396d(y)(1) (2018) (The federal government will pay no less than 90% of the state costs of Medicaid expansion.). And yet it pays as little as 50% of long-term care Medicaid costs in many states. *See* 42 U.S.C. 1396d(b) ("[T]he Federal medical assistance percentage shall in no case be less than 50 per centum"); *see also* Williams, *supra* note 14. This incongruity shows the marginalization of "traditional" Medicaid.

market due to unforeseen demographic and investment conditions."[164] Matters have not improved since.[165]

Absent a private sector fix, the answer would seem to be one of the scenarios that the Commission shared: a comprehensive Medicare benefit for long-term services and supports (LTSS) "financed through a combination of an increase to the current Medicare payroll tax and the creation of a Part A premium."[166] Under this guarantee:

> Qualifying individuals would be eligible for reasonable and necessary LTSS services that would include: Skilled nursing facility care or daily skilled care; home health care without the need for a skilled service; personal care attendant services; care management and coordination; adult day center services; respite care options to support family or other volunteer caregiver; outpatient therapies; other reasonable and necessary services.[167]

This was not the first time a bipartisan commission had recommended such action. In September 1990, the "Pepper Commission," or Bipartisan Commission on Comprehensive Health Care, made its own report to Congress that looked holistically at health care reform needs and included long-term care.[168] It recommended "social insurance for home and community-based care and for the first three months of nursing home care, for all Americans."[169] Under that system, "[p]eople who need nursing home care for short periods would have their resources preserved intact to return home."[170] Recognizing the "urgent needs of the currently disabled and their families" the Commission recommended "that the plan be put into place a step at a time over a 4-year period."[171]

Policymakers continue to discuss a single-payer "Medicare for All" approach to basic health care, without reference to long-term care.[172] However, it is time that

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[164] *See* U.S. Senate Committee on Long-Term Care, *supra* note 10, at 67.

[165] *See, e.g.,* Brendan Williams, "The Truth Behind Long-Term Care Insurance," *McKnight's Long-Term Care News* (July 6, 2018), *https://www.mcknights.com/guest-columns/the-truth-behind-long-term-care-insurance/article/779005/* ("The long-term care insurance market should be our canary in the coalmine. No longer can we delude ourselves into thinking private sector solutions alone can avert a demographic disaster.").

[166] *See* U.S. Senate Committee on Long-Term Care, *supra* note 10, at 67. An effort to fund a long-term care benefit through a payroll tax was introduced in the Washington Legislature in 2017. *See* Ron Lieber, "One State's Quest to Introduce Long-Term Care Benefits," *New York Times* (March 9, 2018), *https://www.nytimes.com/2018/03/09/your-money/washington-state-long-term-care.html* (noting that "[a]s the need to finalize the legislation approached, AARP, citing various unanswered questions, came out against it."). The idea had some editorial support. *See* Editorial, "Use Payroll Tax to Set Up Long-Term Care Benefit," *Everett Herald* (February 15, 2017), *https://www.heraldnet.com/opinion/editorial-use-payroll-tax-to-set-up-long-term-care-benefit/* ("Some will balk at seeing another deduction from their paychecks, but providing for our own long-term care is a responsibility we owe to our children and one that we should no longer avoid."). The author proposed such a tax in 2011. *See* Brendan Williams, "Schools vs. Elder Care," *Everett Herald* (July 10, 2011), *https://www.heraldnet.com/opinion/schools-vs-elder-care/* ("Call it a 'half-cent solution.' A payroll tax of .5% of earnings, split evenly between employers and employees (as the 2.9% Medicare Part A tax is) would generate more than $600 million a year for long-term care."). The effort was being renewed in 2019. *See* Jerry Reilly, "The state and its citizens both need lawmakers to pass the Long-Term Care Trust Act," *Olympian* (January 22, 2019), *https://www.theolympian.com/opinion/op-ed/artic1e2249170 90.html.* Yet, while states can be forgiven for doing their utmost to avert a demographic disaster, a national crisis really requires a national strategy, rather than placing the onus upon states. In Maine, Question 1 before the voters in 2018 would have funded a "Universal Home Care Program" by imposing "a 3.8 percent tax on income and wages over the maximum annual wage amount subject to Social Security taxes, which is now $128,400." Michael Shepherd, "Following the Money on Maine's Home Care Ballot Question," *Bangor Daily News* (September 17, 2018), *https://bangordailynews.com/2018/09/17/politics/following-the-money-on-maines-home-care-ballot-question/*. The measure failed overwhelmingly. *See* J. Craig Anderson, "Question 1 Proposal for Tax-Funded Home Care Headed for Defeat," *Portland Press Herald* (November 7, 2018), *https://www.pressherald.com/2018/11/06/question-1-appears-headed-for-defeat-in-early-returns/*.

[167] *Id.*

[168] S. Rep. No. 101–114 (1990).

[169] *Id.* at 14.

[170] *Id.* at 15.

[171] *Id.*

[172] Chris Farrell, "Could This Idea Help Fix America's Shortage of Home Care Workers?", *Forbes* (August 15, 2017), *https://www.forbes.com/sites/nextavenue/2017/08/15/could-this-idea-help-fix-americas-shortage-of-home-care-workers/* (MIT Professor Osterman has been quoted stating: "Long-term care is absolutely the stepchild of health care on multiple dimensions."). Policymakers already distracted by ACA debate now also must contend with the opioid crisis. *See, e.g.,* German Lopez, "We're Failing in the Opioid Crisis. A New Study Shows a More Serious

Continued

lawmakers refocus their attention on ensuring that Medicare better serves the comprehensive health care needs of the elderly population that it was originally intended to serve.[173] Otherwise, states will flounder in meeting Medicaid demand.

LETTER SUBMITTED BY KATHIE NORTHRUP PLATT

Thursday, August 1, 2019

U.S. Senate
Committee on Finance

To Members of the Hearing:

While the reports to your committee largely focused on reporting and preventing physical and emotional harms to residents of nursing homes and assisted living facilities, these reports also touched on a third area less often addressed because it is less obvious, yet no less serious. I am speaking of financial exploitation and elder financial abuse. Sometimes a facility might be guilty of taking financial advantage of its residents. But more often than not, they would not risk such obvious law breaking. I am speaking instead of an even more insidious form of elder financial exploitation: abuse that is committed by a close relative or family friend of the elder in long-term care. The injury is compounded when the facility suspects this (and even reports this suspicion to other family members of the elder in residence), but then fails to take appropriate action to report it to law enforcement authorities, much less track or follow up, or insist on investigation and prosecution when warranted.

I am currently faced with this exact situation pertaining to my elderly 98-year-old father in the secure memory care unit at the Brunswick at Attleboro Retirement Community in Langhorne, Pennsylvania. Because my elderly father is having all of his physical, social and emotional needs met at a facility that meets the highest standards of care, the unaddressed and unreported elder abuse I would like to bring to the attention of your committee is an abuse that is falling under the radar. That it is hidden makes it no less notorious, dangerous or destructive, but possibly even more so. I strongly believe that suspected financial exploitation of a senior in residence is an abuse that the assisted living facility or nursing home should be required by law to report to law enforcement authorities, and then continually track and follow up until disproven or prosecuted.

I address your committee out of deep concern and helplessness due to the weakness or nonexistence of laws to protect elders from covert financial exploitation and abuse. There is a dangerous absence of laws instructing Assisted Living and Nursing Home Administrators regarding suspected financial exploitation and financial crimes against elder residents. There is, additionally, a serious and hazardous disconnect between agencies tasked with the business of protecting elders against financial and other crimes against their person and property.

When administrators become suspicious of financial crimes and other improprieties being committed by those who have familiar or intimate access to our elderly family member in independent living, assisted living or nursing care, executives and staff ought to be required *by law* to act and involve law enforcement and not just sit idly by or complain to family members of those same seniors, expressing their concerns to us and then tasking us (who have few or no resources and no power) with the full responsibility to investigate and prosecute.

Approach Would Save Lives," *Vox* (August 23, 2018), *https://www.vox.com/policy-and-politics/2018/8/23/17769392/opioid-epidemic-drug-overdose-death-study* ("The opioid epidemic is the deadliest drug overdose crisis in US history—on track to kill more people over the next decade than currently live in entire American cities like Miami or Baltimore."). For policymakers who are reactive, it is easier to focus on the crisis at hand (and their next election), rather than look ahead to the future.

[173] Howard Gleckman, "Americans Are Baffled by Long-Term Care Financing, but Want Medicare to Pay for It," *Forbes* (May 30, 2017), *https://www.forbes.com/sites/howardgleckman/2017/05/3OJamericans-are-baffled-by-long-term-care-financing-but-want-medicare-to-pay-for-it/* ("While a majority of Americans incorrectly think that the current Medicare program pays for long-term care, a growing majority also thinks the program should provide such a benefit."); *see also* Emily Swanson, "Poll: Older Americans Want Medicare-Covered Long-Term Care," AP (May 25, 2017), *http://www.apnorc.org/news-media/Pages/Poll-Older-Americans-want-Medicare-covered-long-term-care.aspx* ("70 percent of older Americans say they favor a government-administered long-term care insurance program, up from 53 percent who said so a year ago.").

I am the only daughter and only living child of Robert F. Northrup, 98, living in the secure memory care unit of the assisted living facility at the Brunswick at Attleboro Retirement Community in Langhorne, Pennsylvania. Five months after my father's second wife died (in December 2011), my family and I helped my father move into the independent living at Attleboro Retirement Community. He was then 91 (April 2012).

Within 2 years my father met and "fell in love" with another resident, Sue, and they married May 18, 2014. Dad was then 93 and Sue was 96. I did not know any of my father's new wife's adult children, but met them for the first time at the wedding. Early on I learned that RD (Sue's middle daughter who lives in Austin, Texas), managed all of Sue's finances. But I gave this no more thought as my father always managed his own business and had assured me (prior to the wedding) that nothing in either his or his new wife' s will would change and that they would keep their bank accounts separate.

Although irregularities became noticeable early on in this marriage in the tenth decade of my elderly father's life, I was notified by the retirement facility of suspected abuses against my father's well-being and wealth soon after his move from independent living to the secure memory care unit January 2019 . As soon as I learned from Attleboro staff (by email to me) that my dad had been moved from Independent Living to the secure memory unit in the assisted living at the Brunswick at Attleboro, I immediately flew up from Texas to Pennsylvania to check on my father and meet with Attleboro staff.

On this occasion (and several occasions afterwards), the Executive Director of Attleboro, MK, confided in me her concerns regarding RD (my father's wife's middle daughter): How RD had tried to prevent the move of my dad from independent living to memory care; how RD had threatened legal action against Attleboro for moving my father to memory care; how RD tried to prevent her own mother from joining my father in memory care (although Sue also suffers significant cognitive decline); how Sue was finally "allowed" by her daughter to move over to assisted living, but not into memory care; how Sue actually does live in memory care with my father—because that is where she wants and needs to be (even though RD insisted in February that her mother sign a contract for an expensive apartment outside of memory care that she has never used); ***how RD persuaded my father to add her as alternate on his POA (even though my father is in the locked memory care unit and deemed totally incapacitated);*** how Attleboro (Executive director and social workers and other staff members) suspect financial exploitation of my father's resources by RD to pay for this unused apartment, as well as other mismanagement of my father's resources; how Sue's other daughters will have nothing to do with their sister RD because they see her exploitation of my father and want to distance themselves from it . . . and the list goes on.

What is obvious to everyone involved is that both my cognitively-impaired father (98) and his cognitively-impaired elderly wife (101) of five years were manipulated by RD, the wife's middle daughter, to the end that RD now has full power and control (durable POA) over both my father's person and property, as well as her mother's person and property. Although every staff member at Attleboro Community, every local elder care and oversight agency in Bucks County, as well as family members on both sides, are aware of or have been notified about the situation and are concerned by, if not deeply disturbed by it, so far no one (in authority at the care facility, or in the social services system, or in law enforcement) has any power or motivation to investigate and prosecute this woman, RD. Meanwhile, everyone looks to me, the non-professional, and the only living child and daughter of my father, to handle this investigation *with resources and power that I do not have!* This adds injury to injury, not only as my father daily suffers the depletion of his lifelong wealth for the ultimate benefit of RD, but also as this exacerbates the angst experienced by myself and by our family as we helplessly watch these crimes against my father—and the depletion of his resources—escalate unaddressed.

While I have been regularly notified by the Long Term Care facility, over the past seven months, of suspected abuses being committed against my father in the secure memory care unit, as a family member only (I am *not* an attorney or law enforcement officer), I am absolutely powerless and personally under-resourced to investigate and prosecute those individuals suspected of foul play (financial crimes and other acts of exploitation including manipulation and emotional abuse) against my at-risk elderly father. Without the full support and involvement of long-term care administrators, the legal community and law enforcement, and a seamless and empowering continuity between agencies (ombudsmen, legal aid, district attorney's of-

fice, network of victim's assistance, etc.), family members such as myself are simply powerless to protect our elderly parents against emotional and financial exploitation and other crimes.

Although I was fully advised by LTC administrators (at the facility that cares for my father) of their suspicions and the high probability of financial abuses taking place, have been prompted to take action, and have been provided much sympathy for my father's (and our family's) predicament, all responsibility for action has been left to me. I am expected to hire an attorney and petition for guardianship, even hire a detective if necessary, or whatever else might be required, to investigate, convict and stop this alleged criminal from her crimes against my father.

The narrative history of dozens, maybe hundreds, of other families who have been made aware of emotional and financial crimes against their elderly parents and who have been tasked with taking legal action against alleged criminals taking advantage of vulnerable elders, has shown how ineffective concerned family members are (even when they have the resources to hire an attorney and pursue justice, often for many years) to "prove" the financial crimes or emotional manipulation committed against their vulnerable elderly parent(s).

I have discovered that there is no end of agencies out there to whom we can turn and pour out our grievances or express our suspicion of emotional/financial abuse. In fact, family members can cry out as long and as loud as we like, and agency officials will listen for a while and agree that the situation is highly irregular, suspicious, even outrageous, and definitely a problem. But, in the end, these agencies tell us that there is nothing they can do. Either by word, or by neglect, agencies and officials shift the full responsibility to handle these alleged crimes back to us—either because officials/agencies are disinterested, otherwise engaged, or powerless.

More often than not, because our elderly parents cannot or will not speak up for themselves (are even unwittingly complicit in these same crimes being committed against them), the authorities, the agencies, even the attorneys themselves, finally tell us that there is nothing they or we can do.Therefore, what is grossly obvious to everyone, must suddenly be ignored. The result is benign neglect, or gross irresponsibility, on the part of those who should be most informed concerned and proactive about protecting the elderly. These same administrators and agency officials have received all the educational and legal training family members have not, yet somehow still lack the authority or mandate to act to protect our elderly parents. It adds insult to injury to watch exploitation go unaddressed because administrators and agencies will do nothing to investigate those suspected of committing financial crimes against this most vulnerable class of society—the aging, the elderly, those with diminished capacity, who are powerless to recognize the crimes being committed against them, to report these crimes, or act in their own best interest.

The problem is: I have not been silent or inactive since my Dad's move to memory care in February, especially in view of the increasing list of concerns and complaints I have received from Attleboro staff, from members of my father's wife's family, and from my own observations of the improper, and allegedly illegal behavior of RD regarding my father's wealth and well-being.

Over the past seven months I have contacted and re-contacted: The Long-Term Care Ombudsman of Bucks County, Legal Aid of Southeastern Pennsylvania, Area Agency on Aging—Older Adult Protective Services, Disability Rights Network of Pennsylvania, Pennsylvania Senior LAW Center, Bucks County Bar Association Lawyer Referral Program, Bucks County District Attorney's Office-Chief of Economic Crimes and Deputy District Attorney, Bucks County Crimes Against Older Adults Task Force, and Bucks County Network of Victim Assistance. I have contacted all the key workshop presenters at the 16th Annual Neff Elder Abuse Symposium 2019 including the Bucks County DA's Office on A Look at Criminal Prosecution/Case Studies; the Bucks County Register of Wills on Rapid Changes in Guardianship Law; Elder Financial Exploitation; and the Bucks County Area on Aging and Court Orders; as well as contacted numerous specialists in the field of elder financial exploitation (including David Brancaccio of Marketplace Radio on Brains and Losses, and Pam Glassner on Last Will and Embezzlement).

Additionally, I have consulted at length with numerous certified elder law attorneys (CELAs), and although I have been advised by Attleboro Community (where my father resides) to petition for guardianship, I have also been warned by those same attorneys (and by other individuals and families who have already pursued the legal route regarding their own elder family member's financial exploitation, spent a small fortune, and failed to stop the exploitation) what a steep, expensive and im-

possible battle this may be when waged against a woman who is more savvy, resourced and experienced than ourselves, with no limit to legal and political power at her disposal providing her with all the leverage she needs to keep doing what she is doing and getting away with is for as long as she likes without conscience, restraint or remorse. Why is she able to do this? Because the LAW is simply too weak or too poorly defined to address these "gray areas"—despite a preponderance of personal reports and evidence that My Father Is Being Financially Exploited.

Ironically, because all of my father's physical, social/emotional and medical needs are being well-managed and met by the LTC, and he is in no immediate danger of physical abuse, he is not a high priority on the DA's (or anyone else's) list. If he made poor choices and allowed his wife's daughter to take over control of all his finances, his will, his estate, and his resources, if he (albeit in a state of cognitive decline) was persuaded to allow his elderly wife's daughter to usurp his POA and manage his wealth in such a way as to preserve his wife's wealth for the eventual benefit of the savvy, unscrupulous step-daughter, while drawing down his own estate to his loss and the loss of his heirs (but unrealized by him in his present state of dementia), then that is "his free choice."

Although I have been consistently proactive since February, contacting and providing in-depth information to every social and legal agency in Bucks County responsible for elder care, oversight and the prevention of elder abuse—continually following up on all of my own, as well as Attleboro's concerns—I have not received any real or practical help. Although Attleboro Retirement Community staff have direct and indirect knowledge of my father's financial exploitation, they rely on me (my father's daughter) entirely to challenge RD (my father's wife's daughter) in court. They will assume no personal responsibility to expose or report the alleged moral and financial crimes against my father they have suspected and continue to suspect.

Likewise, the elderly wife's own family members (her eldest and youngest daughters and their spouses) who have been witnesses to the "inappropriate" and illegal behavior of their sister (they will no longer even talk to RD), will do nothing, but have abdicated entirely, wanting to distance themselves as far as possible from their sister and from any implication that they had knowledge of RD's crimes as they occurred over the past 5 years. Everyone (personal and professional) seems to rely on me entirely to take legal action—although the track record shows that exploited seniors and their family members rarely "win" against the financial exploiter.

I believe that it is the responsibility of Law Enforcement: the Bucks County DA's office, the Attorney General of Pennsylvania, even the US Attorney's Office, if necessary, to thoroughly investigate the allegations against RD, to subpoena financial documents, to follow the paper trail, and to interview all the staff members and care givers at Attleboro Community, the social service agencies involved in my father's care and legal protection, the CPAs, attorneys, family members on both sides, ombudsmen, etc., in order to determine the root cause of the mounting allegations against RD, to ascertain their validity, or not, and to take appropriate legal action.

While we all "know" that the financial abuse of my father is occurring—and has been for some time—no one in authority is willing to take responsibility to report this or to thoroughly investigate this due to the relative "invisibility of the crime" (being committed by a retired "cost analyst specialist") and due to the lack of clear guidelines regarding jurisdiction and responsibility to report. Although, as far as we know, my father has always received excellent social-emotional, physical care at Attleboro, they and other agencies ***have failed to report to local law enforcement agencies the suspected financial crimes against my father*** that they have every reason to suspect based on a preponderance of circumstantial (and other) evidence that has been mounting over the past 5 years since my father's marriage (at age 93) to Sue (then 96).

Today RD has assumed full control over the person and property of both her mother, Sue, and of my father, Robert Northrup, against the protests of Attleboro and family members on both sides. But no agency so far contacted will seriously or actively investigate this, although we have sounded and re-sounded the alarms, and expressed our outrage and concern. Please understand that family members are relatively powerless if the law does not have guidelines and standards in place to protect elders, even those still deemed fully capacitated, from the financial and emotional exploitation to which their age renders them vulnerable.

As is frequently the case, when my father married Sue in the tenth decade of his life, he was (unknown by us at the time) already at the top of the slippery slope

of cognitive decline. It didn't take much for Sue's middle daughter, RD, to nudge him along in a direction that not only served her best interest (change his will into a trust for her mother, commingle my father's accounts with her mother's, use my father's resources entirely to pay for her mother's living and care while building up her mother's social security in a joint mother-daughter account, etc). These subtle and progressive changes eventually lead to RD's complete and, so far, unchallenged overthrow of my father's person and property, for the shrewd purpose of building up wealth for herself and her own family at my father's expense.

While I do not personally have the power or resources to investigate, expose, fight or stop this woman's financial abuse of my father, I know that you do and that something can and must be done. Please understand that the law must go above and beyond addressing the more obvious physical abuse of seniors in long-term care facilities, to address the often hidden abuse by relatives or "friends" of seniors resulting in the extortion of their lifelong wealth and legacies. Although often "invisible" and hidden from view, and even unnoticed by the senior himself who is suffering the abuse, we—the family members who know and love our parent best—know and suffer on his/her behalf, even as we lose hold of the legacy we were asked to protect.

Below Are Excerpts From the Senate Finance Committee Hearing Members Statements That Reinforce and Illuminate the Concerns I Have Expressed:

Senator Ron Wyden states that "instances of physical, sexual, mental and emotional abuse in nursing homes appear to be on the rise" and that "abuse happened in homes of all ratings, top and bottom. A good rating did not indicate that a nursing home prevented abuse."

Megan H. Tinker, Senior Advisor for Legal Affairs, OIG, expressed that "A SNF must ensure that all incidents involving alleged abuse and neglect are reported immediately to the administrator of the facility and the Survey agency" (5) but "***Providers frequently failed to alert law enforcement to incidents of potential abuse or neglect . . . even though all States require certain individuals to report suspected abuse, neglect or exploitation of vulnerable adults"*** (6).

". . . (C)overed individuals are required to report any reasonable suspicion of a crime, such as certain instances of abuse, neglect, or exploitation" (7). Furthermore, "CMS does not require all incidents of potential abuse or neglect and related referrals made to law enforcement to be recorded and tracked in their complaint and incident tracking system" (5). And yet, "Analyzing the data can help identify individual incidents of unreported abuse or neglect, and patterns and trends of abuse or neglect involving specific providers, beneficiaries, or patients who may require immediate intervention to protect their health, safety and rights" (7).

"OIG investigates potential criminal and civil violations and pursues administrative actions to hold accountable those who victimize residents of nursing homes" (9) and ***"CMS and law enforcement cannot adequately protect victims of abuse and neglect from harm if they do not first know the harm is occurring"*** (10).

John E. Dicken, Director, Health Care, GAO, reports that ***"nursing home residents often have physical or cognitive limitations that can leave them particularly vulnerable to abuse" and "incidents of abuse may be underreported"*** (1).

Unfortunately "This testimony addresses physical abuse, mental and verbal abuse—which we refer to as mental/verbal abuse—and sexual abuse but does not address other forms of abuse, such as financial abuse or neglect" (Footnote 2) (1).

"Despite federal law requiring nursing homes to self-report allegations of abuse and covered individuals to report reasonable suspicion of crimes against residents, CMS has not provided guidance to nursing homes on what information they should include in facility-reported incidents, contributing to a lack of information for state survey agencies and delays in their investigations. . . . Therefore, facility-reported incidents play a unique and significant role in identifying abuse deficiencies in nursing homes, making it critical that incident reports provided by nursing homes include the information necessary for state agencies to prioritize and investigate" (5–6).

"Because CMS requires a state survey agency to make referrals to law enforcement only after abuse is substantiated—a process that can often take weeks or months—law enforcement investigations can be significantly delayed . . . delay in receiving referrals limits their ability to collect evidence and prosecute cases. . . . As such we recommend that CMS require state

survey agencies to immediately refer to law enforcement any reasonable suspicion of a crime against a resident . . . in order to ensure a prompt investigation of these incidents" (7).

Robert B. Blancato, National Coordinator, The Elder Justice Coalition, writes, ***"Ending elder abuse, neglect, and exploitation is a bipartisan issue and goal***. . . . The Elder Justice Coalition is a non-partisan 3,000-member group dedicated to advancing elder justice policy at the federal level. . . . Members provide direct services to elder abuse victims, such as the National Adult Protective Services Association and the National Association of State Long-Term Care Ombudsmen, or provide public outreach and advocacy on elder abuse. . . ."

"Justice Department figures say one in ten older adults are victims of elder abuse. We also know from reports that ***victims of financial elder abuse lose at least $3 billion a year, with other reports suggesting dramatically higher losses"*** (1).

"The same federal report noted that ***many elder abuse victims have organic conditions such as dementia, brain injuries and other factors that lead to diminished or limited cognitive capacity. They are more susceptible to abuse, neglect and financial exploitation"*** (2).

"All forms of elder abuse, apart from self-neglect, are crimes and its victims are crime victims" (4).

"The Elder Abuse Forensic Center model is designed to provide case review by a multidisciplinary team, consultation, assessment, tracking, and help to implement person-centered care plans in the most complex cases of abuse, neglect, exploitation, and self-neglect of older adults. Research published by The Gerontological Society of America states that ***'elder abuse forensic centers improve victim welfare by increasing necessary prosecutions and conservatorships and reducing the recurrence of protective service referrals.*** Elder abuse forensic centers provide a process designed to efficiently address client safety, client welfare and protection of assets'"(5).

"Much of the abuse, neglect and exploitation that takes place behind the closed doors of long term care facilities is severely underreported by residents, family, staff, and the state survey agencies. There are various reasons for this including the fear of retaliation."

"Better oversight by CMS is needed that includes tools that nursing homes are mandated to use to record and report abuse and perpetrator type. We need to be sure the reports are made in a timely manner for the treatment and safety of the resident" (6).

"Failure to improve the federal response to elder abuse may be one of the worst examples of ageism in public policy" (9).

Mark Parkinson, President and CEO, AHCA, comments: "***'CMS guidance was not clear and therefore SNFs interpreted it inconsistently.'*** They did not try to hide these cases; instead they did not believe the cases met the CMS definition so they did not need to report them. It was not due to lack of awareness that education will correct, but confusion as to the CMS definition and reporting requirements. Interestingly, the OIG report goes on to state that even the survey agency officials across states have different interpretations of the term' suspicious. 'Ultimately,' the OIG concludes that, ***'the lack of clear guidance from CMS results in incidents going unreported by the SNFs'***" (4).

"The Elder Justice Act needs to require that CMS and other agencies use the same definition of abuse and neglect, separate them in enforcement and tracking, and standardize the reporting guidelines (including time to report) for all health care settings to be consistent" (4).

Lori Smetanka of The National Consumer Voice for Quality Long-Term Care reports: ***"My colleagues and I communicate daily with residents, family members, citizen advocates, and long-term care ombudsmen who see and experience the failures of the systems designed to protect residents"*** (1).

"There have been significant changes in the ownership and management of nursing homes, with ***an increasing number of nursing facilities part of a multi-facility or corporate structure,*** and an increase in private equity ownership. Division of ownership and management is occurring among numerous affiliated entities that derive profits, but who are not responsible for the quality of care. Further, many of the decisions that affect care, including operational budgets and staffing levels,

are made at the corporate level, yet CMS oversight is limited to individual facilities, (4).

"***Examples of inadequate nursing home oversight include low complaint substantiation rates and findings of harm in less than 5% of deficiency citations.*** Enforcement has been further weakened by policy changes that CMS has implemented" (5).

"New rules provide less protections for residents and less accountability for nursing facilities by, among other things, weakening standards relating to infection prevention, use of antipsychotic medications, and responding to resident and family grievances" (6).

"Numerous GAO and OIG reports . . . show the need for continued federal and state action to strengthen elder abuse reporting, prevention, and response. ***The failure of appropriate reporting of abuse or suspicions of abuse is unacceptable. Failures to report prolong the victimization and suffering of those being abused*** and put at significant risk other residents who are in contact with the abuser."

"**We recommend** that Congress take the following actions: (1) add state surveyors to the list of covered individuals who are required to report suspicion of abuse or neglect to law enforcement; (2) **direct CMS to fully enforce the Affordable Care Act's requirement for individuals to report possible criminal acts to law enforcement;** (3) impose civil money penalties against the nursing home or other licensed entity for failure to report abuse or suspicions of a crime; (4) increase funding for the Long-Term Care Ombudsman Program to enhance the program's capacity to assist in abuse prevention and advocate for residents who have been victimized" (7).

"The needs of nursing home (and assisted living) residents is significant. Residents' acuity level has (de)creased, and the majority have some form of dementia. ***The increased prevalence of physical and cognitive impairments makes residents more at risk of abuse and neglect.*** We can do better" (8).

Thank you for reviewing my statement and for entering it into the record.

Sincerely,

Kathie Northrup Platt

LETTER SUBMITTED BY LADAWN WHITESIDE

August 6, 2019

U.S. Senate
Committee on Finance
Dirksen Senate Office Building
Washington, DC 20510–6200

Re: Promoting Elder Justice: A Call for Reform Hearing 7/23/19

To Whom It May Concern:

I listened to the Senate Finance Committee hearing of July 23, 2019 with anticipation. I have worked in the elder care industry for over 30 years. I have been a direct care worker, regulator, and now am an Abuse in Late Life Advocate and Elder Care Mediator in Montana. I applaud your efforts to protect and empower older adults.

I live in Montana which is one of the few States that do not have required background checks for people working as paid caregivers for older adults. There are many pros and cons associated with background checks. I believe that people think a background check (criminal history check) provides more of a safety net than it actually does. I believe that the nursing home industry is already held to a very high standard with regard to the safety of residents. I believe that the screening requirements currently in the regulations give facilities options to use the best method for them. Different sizes and cultures in communities make some tools for elder abuse prevention better than others. A background check is not the only tool for ensuring the safety of older adults.

Instead of adding additional requirements to nursing homes (most regulated industry in healthcare), we need to focus on services/caregiving provided in community

based settings. The majority of elder abuse occurs in the home setting, not in nursing homes as the public believes.

Nursing homes have been required to report all allegations of abuse for over a decade. Last time I counted, the federal abuse regulations were 90 pages long. We now have the data necessary to improve upon the preventive system in nursing homes. We can define reporting requirements in a way that decreases the noncriminal reports and investigations being completed. We are now educating the law enforcement system to take over the investigation of the massive amount of criminal and non-criminal abuse allegations. I applaud this direction as the investigations will now be conducted by an outside entity. However, the current Department of Justice system is not capable of investigating all of these allegations in a timely manner. The DOJ does not have adequate resources to do keep up with existing workload caused by the federal nursing home regulations: Particularly with victims who are older and/or fragile and ill, they cannot wait for 9 months for their case to be investigated by law enforcement.

The five day time frame required for nursing homes at CFR 42.483 is appropriate and ensures evidence is not lost. I am advocating for the Medicaid Fraud Control Units across the county take over the majority of the medical industry investigations and that the organizations investigating be made a higher priority to enable timely investigation.

My second concern raised by the hearing is that the assisted living (AL) industry was absent during the hearing. The people being cared for in assisted living are the same type of residents we see in nursing homes. They are ill, not able to provide their own care, receive and benefit from a lot of services paid for by Medicare. These people are directly affected by criminals who are trying to take advantage of them. For the following reasons, I believe the assisted living industry needs more attention than nursing homes:

- The majority of people living in AL facilities are paying with personal funds. As mentioned in the hearing, 2/3 of the residents living in nursing homes are Medicaid beneficiaries. Just living in an AL setting results older adults to be a *target for financial exploitation.* These vulnerable people receive an inordinately high number of "robo" calls and solicitations. I feel that nonprofits target this group of people for fundraising purposes because they continue to contribute even if they don't have the resources anymore. If it comes in the mail as a bill, they believe they must pay it. It meets my definition of coercion as opposed to self-determination.
- Nationally, there are *almost no regulations for AL facilities,* despite the clientele being the same who live in nursing homes. During the hearing it was reported that the profit margin for nursing homes was .5%. Congress should require the AL industry, with huge profit margins to comply with the same (or better) regulations as nursing homes. The only option in Montana AL facilities to report abuse is a local 911 number and Adult Protective Services workers. Other than State definitions of abuse, the AL industry has almost no reporting requirements for abuse. Compared with nursing homes, this is unacceptable to me.
- *The Durable Medical Equipment (DME) industry is constantly under scrutiny for their business methods and taking advantage of older Americans with physical disability's.*
- Staff training requirements in ALs are largely company driven as opposed to federal regulations driving the industry. *An AL isn't required to do hire staff that have met a specific training criteria such as a Skills Checklist or a back ground check or a criminal history.*

My third comment is regarding the long term care Ombudsman program. This wonderful program needs support, direction and funding. In Montana local long term care Ombudsman wear so many hats they are spinning in circles. They have too many bosses and lack appropriate or adequate funding and staffing. This Committee should direct pressure on the individual States to prioritize the long term care Ombudsman and recognize these workers for the front line work that they do to improve the lives of older adults.

My fourth comment is about arbitration in both nursing homes and AL facilities. Arbitration takes the power and control away from residents and their decision makers. Fundamentally, I am against arbitration. Mediation is the avenue Congress should endorse; it keeps the power in the hands of the people involved.

Lastly, I am appreciate of the IRS tax deduction for AL and nursing home care to preserve estates large and small. This incentive to "pay their own way" is a great

option and recognizes the high cost of caregiving. After all, people prefer to stay at home as long as possible. We tax payers want people to pay their own way as long as possible. Compare the price of AL in the USA. It's not more affordable than living in a nursing home.

Sincerely,

LaDawn Whiteside

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