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EXAMINING FEDERAL EFFORTS TO ENSURE QUALITY
OF CARE AND RESIDENT SAFETY IN NURSING HOMES
THURSDAY, SEPTEMBER 6, 2018
House of Representatives
Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
Washington, D.C.

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

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

Also present: Representative Bilirakis.

Staff present: Jennifer Barblan, Chief Counsel, Oversight
and Investigations; Samantha Bopp, Staff Assistant; Lamar Echols,

26 Counsel, Oversight and Investigations; Ali Fulling, Legislative
27 Clerk, Oversight and Investigations, Digital Commerce and
28 Consumer Protection; Christopher Santini, Counsel, Oversight and
29 Investigations; Jennifer Sherman, Press Secretary; Julie
30 Babayan, Minority Counsel; Jeff Carroll, Minority Staff Director;
31 Tiffany Guarascio, Minority Deputy Staff Director and Chief
32 Health Advisor; Chris Knauer, Minority Oversight Staff Director;
33 Jourdan Lewis, Minority Staff Assistant and Policy Analyst; Kevin
34 McAloon, Minority Professional Staff Member; and C.J. Young,
35 Minority Press Secretary.

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

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

Protecting our most vulnerable citizens is among the most fundamental responsibilities entrusted to the federal government and it is also a responsibility that we as Americans all share.

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

However, reports issued by the Department of Health and Human Services Office of Inspector General and the Government Accountability Office, along with all too frequent press reports, detail horrible cases of abuse and neglect occurring in nursing homes raises questions as to whether CMS is fulfilling its obligations to residents. For example, in 2014, OIG found that

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

66 Last year, reports emerged out of Florida of the deaths of
67 at least a dozen residents of the Rehabilitation Center at
68 Hollywood Hills after the facility's air conditioning system
69 failed in the immediate aftermath of Hurricane Irma. According
70 to state regulators, temperatures at the facility reached nearly
71 a hundred degrees and the facility deprived residents of timely
72 medical care despite being located across the street from a fully
73 functioning and functional hospital. CMS described the
74 events at this nursing home as a complete management failure and
75 terminated the facility from the Medicare and Medicaid programs
76 noting that the conditions at the facility constituted an
77 immediate jeopardy to residents' health and safety. Previously,
78 this facility's owner entered into a settlement agreement with
79 the federal government to resolve allegations he and his
80 associates had paid kickbacks and performed medically unnecessary
81 treatments to generate Medicare and Medicaid payments at another
82 Florida healthcare facility in which he had an ownership interest.
83 Despite this history and last year's tragedy at that person's
84 rehabilitation center, we have learned that the facility's owner
85 continues to maintain an ownership interest in at least 11

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facilities participating in the Medicare and Medicaid programs.

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

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

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

When Hurricane Katrina devastated the Mississippi Gulf

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111 Coast, now 13 years ago, there was no fatality or major problem
112 at a nursing home in Mississippi. And I am proud of these
113 successes in my home state. What are the best practices being
114 utilized at these facilities that if applied everywhere could
115 yield positive outcomes for nursing home residents?

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

123 Ms. DeGette. Thank you so much, Mr. Chairman. I guess as
124 proof that this subcommittee often, most often, works in a
125 bipartisan way, my opening statement is pretty much exactly the
126 same opening statement you just made down to the example of the
127 Hollywood Hills tragedy after Hurricane Irma when 14 people died.

128 So I am going to submit my written statement for the record,
129 I just want to make a couple of observations. The first
130 one is some of us have been on this subcommittee for many, many
131 years and those of you who have been here you know that for all
132 of these years we have struggled to address the issue of quality
133 care at nursing homes. Both the IG at HHS and also the GAO have
134 consistently raised issues over the years about how the states
135 and CMS oversee the nursing home industry and every so often we

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136 have a real tragedy like this Hollywood Hills tragedy.

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

146 So we do this over and over again, but yet, yet, one-third
147 of Medicare residents have experienced harm. Now the IG has made
148 recommendations for how to improve these issues. CMS needs to
149 articulate to us today what concrete steps the agency is making
150 to improve this. I also want to know what progress CMS is making
151 on implementing the updated health and safety regulations that
152 were finalized in 2016 after a lengthy rulemaking process.

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

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

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

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

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

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

185 I think it is important to put it all in context as well.

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186 According to information released by the Centers for Medicare
187 and Medicaid Services, more than three million individuals rely
188 on services provided by nursing homes at some point during every
189 year. And on any given day, 1.4 million Americans reside in more
190 than 15,000 nursing homes across our country and the overwhelming
191 majority of these nursing homes provide high quality, lifesaving
192 care to their residents. We know that too.

193 I have heard from many seniors and their families in my
194 district about how they or their loved ones are receiving
195 excellent, around-the-clock care at their nursing homes and they
196 go above and beyond. One provider I spoke with recently has a
197 facility down in Redding, California. And when the fires were
198 threatening Redding he chartered buses, had them on the ready
199 with 200 seats, made arrangements, and all of this was happening
200 very, very quickly to be able to move patients, residents to a
201 facility many miles away in Klamath Falls, Oregon, if need be.

202 As it turned out he didn't have to do that evacuation, but they
203 were ready. Unfortunately, this doesn't appear to be the case
204 in all nursing homes.

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

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

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

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

233 For example, HHS OIG has examined whether states properly
234 verify that deficiencies identified during nursing home
235 inspections are corrected. In some instances, such as my state

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of Oregon, HHS OIG found the state properly verified that facilities corrected deficiencies after they were identified and during inspections.

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

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

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

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261 to thank our witnesses for being a part of this important
262 conversation. We very much value and appreciate your testimony.

263 With that Mr. Chair, unless anyone else wants the remainder
264 -- Dr. Burgess chairs our Subcommittee on Health -- I yield
265 the balance to you. Mr. Burgess. Well, thank you, Chairman
266 Walden.

267 And I just want to mention that like Representative DeGette,
268 in January of 2006 this subcommittee held a hearing, field
269 hearing, in New Orleans, Louisiana, dealing with just this issue.

270 So this morning it is important to see not just one of the lessons
271 learned but how it is the implementation of those lessons and
272 how really report not just to us, on us, how we are doing in
273 overseeing the oversight that the agency is supposed to provide
274 to the facilities that are taking care of our seniors.

275 So thank you, Mr. Chairman, for doing this hearing and I
276 will yield back. Mr. Harper. The gentleman yields back.

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

279 Mr. Pallone. Thank you, Mr. Chairman. Nursing home
280 residents are among our most vulnerable populations who are often
281 unable to care for themselves and require personal attention.

282 Many of us have had loved ones in the care of nursing homes or
283 skilled nursing facilities so we can all appreciate the need to
284 ensure these facilities are providing high quality care. Most
285 of the time nursing homes are staffed by compassionate

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286 professionals who want to provide quality care to those who need
287 it and these professionals are strong allies too in our efforts
288 to ensure residents are properly taken care of.

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

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

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

310 And that is where the Centers for Medicare and Medicaid

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

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

CMS also relies on state survey agencies to conduct inspections of nursing homes on CMS' behalf, but some states have been better than others at ensuring high quality care. OIG's audits have revealed that several states fell short in investigating the most serious complaints and many had difficulty meeting CMS' standards. Workforce shortages and inexperienced surveyors at the state level have also led to the understatement of serious care problems. And, hereto, OIG and GAO have found

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336 problems with CMS' oversight of the state agencies. We need to
337 hear what CMS needs to do better or differently to ensure federal
338 requirements are being followed.

339 And, finally, CMS has yet to finalize and enforce some 2016
340 regulations to update and strengthen the nursing home standards.

341 These regulations address critical areas such as staff training
342 and protections against abuse, among other issues. However, last
343 year, CMS issued a moratorium on enforcement of many of these
344 regulations. And it is important to hear the input of industry
345 and consumer groups to ensure regulations are done right, but
346 without actually enforcing these rules it is unclear how CMS will
347 ensure the quality and safety of our nation's nursing homes.

348 So Dr. Goodrich needs to articulate today how CMS is
349 considering the concerns of the industry and consumers while also
350 meeting its responsibility to ensure high quality care in nursing
351 homes. I yield back, Mr., I mean unless anybody else wants the
352 time, but I don't think so. I yield back. Mr. Harper. The
353 gentleman yields back. I ask unanimous consent that the members'
354 written opening statements be made part of the record. Without
355 objection, they will so be entered into the record. I also ask
356 unanimous consent that members of the full committee on Energy
357 and Commerce not on this subcommittee be permitted to participate
358 in today's hearing.

359 I would now like to introduce our witnesses for today's
360 hearing. Today we have Dr. Kate Goodrich, the Director of the

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361 Center for Clinical Standards and Quality, and Chief Medical
362 Officer at the Centers for Medicare and Medicaid Services. We
363 welcome you today.

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

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

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

373 Let the record reflect that all three have indicated no.

374 The chair then advises you that under the rules of the House
375 and the rules of the committee you are entitled to be accompanied
376 by counsel. Do you desire to be accompanied by counsel during
377 your testimony today?

378 All of the witnesses have indicated no.

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

381 [Witnesses sworn.]

382 Mr. Harper. Thank you. You may be seated. You are now
383 under oath and subject to the penalties set forth in Title 18
384 Section 1001 of the United States Code. You may now give a
385 5-minute summary of your written testimony.

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386 And we will begin with you, Dr. Goodrich, and you are
387 recognized for 5. We would ask that you pull the microphone a
388 little closer to you and make sure that the mike is on. And you
389 know the light system is such when it gets to yellow you have
390 1 minute. Red, the floor will not open up, but do bring it in
391 for a landing, okay. Thank you.

392 You may begin.

393 STATEMENT OF KATE GOODRICH, M.D., DIRECTOR, CENTER FOR CLINICAL
394 STANDARDS AND QUALITY, AND CHIEF MEDICAL OFFICER, CMS; RUTH ANN
395 DORRILL, REGIONAL INSPECTOR GENERAL, HHS OIG; AND, JOHN DICKEN,
396 DIRECTOR, HEALTH CARE, GOVERNMENT ACCOUNTABILITY OFFICE (GAO).

397

398 STATEMENT OF KATE GOODRICH

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

402 Resident safety is our top priority in nursing homes and
403 all facilities that participate in the Medicare and Medicaid
404 programs. Every nursing home must keep its residents safe and
405 provide high quality care. Monitoring patient safety and quality
406 of care in nursing homes requires coordinated efforts between
407 the federal government and the states.

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

417 In cases of immediate jeopardy, meaning a facility's

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

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

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

We are always taking steps to enhance our quality and safety oversight efforts. Last fall, surveyors began verifying facility compliance with CMS' updated and improved emergency preparedness requirements. Facilities are now required to address location-specific hazards and responses, must have emergency or standby power systems and ensure they are operational during an emergency, develop additional staff training, and

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implement a communications system to contact necessary persons regarding resident care and health status in a timely manner.

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

Promoting transparency is another key factor to incentivizing quality. By using a five-star quality rating system, our Nursing Home Compare Web site provides residents and their families with an easy way to understand meaningful distinctions between high and low performing facilities on three factors -- health inspections, quality measures, and staffing.

In April of this year, we took steps to make staffing data more accurate. The new payroll-based journal data provide unprecedented insight into how facilities are staffed which can be used to analyze how facility staffing relates to quality and patient outcomes.

Under the new systems, facilities reporting 7 or more days in a quarter with no registered nurse hours or whose audits

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identify significant inaccuracies between the hours reported and the hours verified will receive a one-star staffing rating which will reduce the facility's overall rating by one star.

CMS greatly appreciates and relies on the work of the Government Accountability Office and the HHS Office of the Inspector General to inform our efforts. We have implemented a number of recommendations in this area and we look forward to additional recommendations to help us continuously improve our programs.

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

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

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493 [The prepared statement of Dr. Goodrich follows:]

494

495 *****INSERT 1*****

496 Mr. Harper. Thank you, Dr. Goodrich.

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

499 STATEMENT OF RUTH ANN DORRILL

500

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

503 I have been visiting nursing homes on behalf of the OIG for
504 20 years. When you speak with the people who have chosen to spend
505 their professional lives in these settings, they will tell you
506 that nursing home care is incremental. By that I mean that the
507 gains and the losses can be small and around the margins.

508 Nursing homes can be places of comfort and healing. They
509 can make the difference between someone having 10 more good years
510 or a downward spiral. But it's important to recognize that people
511 who enter nursing homes are at low points at times of crisis.

512 They often have not only an acute condition that landed them
513 there in the first place, but they have many competing
514 comorbidities and complex conditions on top of that.

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

523 First, in regard to harm, OIG has expended extensive time

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

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

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

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

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at that time to take immediate action to monitor claims and to enforce against those who fail to report. OIG also works in the law enforcement side with our partners to hold accountable those who victimize residents. Next, on emergency preparedness.

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

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

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

Finally, I want to further emphasize the critical role of the state agencies in citing deficiencies when homes aren't up

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

In closing, the through line here is that while CMS has taken steps to create a framework for improvement, all progress will lie in the execution on the part of CMS, on the part of the state agencies, and on the part of the nursing homes. This means focused education and accountability from CMS and also staying alert to the impact of changes. Are the requirements understood, the new requirements by inspectors and homes are they practical?

Do they improve care? None of that can really be assumed and the consequences are great. OIG is recommending that CMS do more to protect nursing home residents and we are committed to that as well. We have ongoing work assessing a number of areas and we thank you for your ongoing leadership in this area and for the opportunity today.

[The prepared statement of Ms. Dorrill follows:]

*****INSERT 2*****

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598 Mr. Harper. Thank you, Ms. Dorrill.

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

STATEMENT OF JOHN DICKEN

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

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

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

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

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

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

Third, in the 2016 report we found CMS did not systematically prioritize recommended changes to improve its Nursing Home

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651 Compare Web site. In several factors it limited consumers'
652 ability to use CMS' five-star rating system. CMS agreed with
653 these recommendations and earlier this year completed actions
654 establishing a process to prioritize website improvements and
655 adding explanatory information about the five-star system. But
656 CMS has not yet acted on other recommendations including providing
657 national comparison information that could help consumers better
658 make distinctions between nursing homes.

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

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

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676 resources.

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

680 [The prepared statement of Mr. Dicken follows:]

681

682 *****INSERT 3*****

683 Mr. Harper. Thank you, Mr. Dicken.

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

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

693 Ms. Dorrill. Yes, thank you for the question. It certainly
694 is true that we have considered this a top management challenge
695 for years and we would love to have that removed from the list.

696 But unfortunately the problems remain. And I think it is
697 important to note that although so many of these problems are
698 longstanding that we are in a different place in time so the heavy
699 lift with revising recommendations that has been done, when I
700 said in my statement that we have a framework I think that's
701 correct. And so we are at a different place than we were when
702 we cited those TMCs over the years.

703 Mr. Harper. Is that a better place?

704 Ms. Dorrill. Yes. I think it's a first step, absolutely.

705 And that but the proof will be in the execution of that, that
706 sometimes a requirement and the actions of the homes just like
707 emergency planning can be miles apart. And so, but that first

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708 step was an enormous one and an important one. And so we would
709 hope as we see execution over the next couple of years that we
710 might be able to eliminate this concern from our top management
711 challenges.

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

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

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

725 Mr. Dicken. Yeah, thank you. And I think as you note that
726 we do have a long-term body of work and many of those same types
727 of issues have occurred. We are pleased that over the years CMS
728 has implemented many of the recommendations we've had and made
729 a number of changes. Certainly we've seen improvements in things
730 like training of surveyors, a more standardized methodology for
731 surveyors. We do continue to see that there's important need
732 to make sure that information that CMS is receiving is accurate

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733 and that they're using it for assessing states consistently.

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

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

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

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

753 Mr. Harper. And, Dr. Goodrich, if I can ask you, you know,
754 a question. Obviously in my opening statement I mentioned the
755 terrible tragedy in Florida at Hollywood Hills at the
756 Rehabilitation Center. And I know CMS terminated the facility
757 from Medicare and Medicaid and has, you know, obviously recognized

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758 how horrible that is.

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

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

769 Mr. Harper. Yes.

770 Dr. Goodrich. -- from having ownership interest in
771 Medicare facilities. Medicare can only bar an individual who
772 has been convicted of a felony or who is on the OIG exclusion
773 list.

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

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

782 Mr. Harper. Thank you, Dr. Goodrich.

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

785 Ms. DeGette. Thank you.

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

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

797 Dr. Goodrich. Sorry. That is correct.

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

803 Dr. Goodrich. Yes, that is correct.

804 Ms. DeGette. And as I said in my opening statement, since
805 the rules have been finalized CMS has taken several actions that
806 could delay some of them or roll them back altogether. First
807 of all, the rules were designed to be implemented in phases, but

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808 not all the phases have been implemented yet.

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

815 Dr. Goodrich. We are currently in the process as you
816 mentioned of implementing the rule that we finalized in 2016.

817 We are on target for implementing all three of the phases and
818 that is underway now.

819 Ms. DeGette. Okay. And what is your timeframe for
820 implementing all of the phases?

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

825 Ms. DeGette. Okay.

826 Dr. Goodrich. Phase 2, we began implementation and
827 surveying and enforcing on November 28th of 2017, so that is
828 underway now. We've surveyed about --

829 Ms. DeGette. It has been about a year.

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

832 Ms. DeGette. And how long will that take?

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

836 Ms. DeGette. Okay. And so let me just ask the question
837 again. Do you anticipate that all of the 2016 rules will be
838 implemented?

839 Dr. Goodrich. Yes, we are on track to implement the 2016
840 final rule.

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

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

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

855 Ms. DeGette. Yes.

856 Dr. Goodrich. Shortly thereafter, Department of Health and
857 Human Services was sued for an injunction, a preliminary and

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858 permanent injunction to stop CMS from enforcing that ban on
859 pre-dispute arbitration. The court granted a preliminary
860 injunction in November of 2016, so we currently cannot enforce
861 what we finalized --

862 Ms. DeGette. Did by court order?

863 Dr. Goodrich. Yes.

864 Ms. DeGette. And what is the status of that lawsuit, do
865 you know?

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

868 Ms. DeGette. If you could get us the status of that lawsuit
869 that would be --

870 Dr. Goodrich. Certainly.

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

881 So we will do everything we can, I think, to make sure that
882 we can enforce that 2016 rule that people don't have to be forced

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883 to sign arbitration agreements. With that I yield back.

884 Mr. Harper. The gentlewoman yields back.

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

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

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

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

902 Dr. Goodrich. Yes, thank you for the question. So, first,
903 I want to say we very much appreciate the work of the OIG and
904 the GAO in the oversight of our programs. They really help to
905 make our programs better and we have concurred with the vast
906 majority of their recommendations particularly on this issue
907 around state service oversight, state agency oversight.

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

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

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

927 The Chairman. Ah, okay.

928 Dr. Goodrich. And then finally we are in the process right
929 now of really overhauling the State Performance Standards System.

930 This is a system that we've had underway for awhile, but again
931 in response to the recommendations from the OIG and the GAO we
932 began an effort again in April of this year to evaluate this entire

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933 program to identify ways to improve it. It's a very large-scale
934 effort, will take at least a year to do but is well underway.

935 And it's really focused on improving the efficiency and the
936 effectiveness of measuring and improving state performance.

937 The Chairman. Right.

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

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

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

954 It is hard to, as we all know there are medical shortages
955 in terms of nurses and aides and everybody else and it just struck
956 me that would my mother have been better off with less reporting
957 and paperwork and somebody that actually was checking on her more

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958 often. Do you know what I mean? And we have got to have both,
959 it is finding this right balance. But boy, I hope somebody is
960 looking at just the layer, a layer, a layer we tend to add on
961 to address a single problem that may occur in Florida and so we
962 think we have to do this everywhere.

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

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

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

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

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

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

Irma knocked out power across much of Florida as its strongest winds swept from Key West to Jacksonville, so most of the skilled nursing centers asked for restoration of electricity.

But Florida is served by private electric companies and municipal utilities and none are directed by the state, so the Governor's office could only request that particular nursing homes be given priority.

Twelve patients later died of overheating at a nursing home that called Scott's cell phone three times. Its administrators say Scott's staff didn't get them help restoring the air conditioning but we know it was a significant management failure

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1008 as well by the owners of Hollywood Hills. This cannot be the
1009 answer for emergency preparedness.

1010 So I understand now there are new requirements that went
1011 into effect in November of 2016. CMS is now surveying states.
1012 That began last year. What have we found? Are the states
1013 following through? I will let you begin, Doctor.

1014 Dr. Goodrich. Absolutely. Thank you for the question.
1015 As you mentioned, we did finalize the emergency preparedness rule
1016 in November of 2016. This applied to all Medicare-certified
1017 facilities certainly including long-term care facilities or
1018 nursing homes. We began verifying that compliance in November
1019 of 2017.

1020 So far we have surveyed about 75 percent of facilities.
1021 We anticipate we will have surveyed across the country a hundred
1022 percent of facilities by February of 2019. As you noted, there
1023 is a need for proper communications systems when there is a
1024 disaster and one of the components of the emergency preparedness
1025 rule that facilities are now required to adhere to is to develop
1026 and maintain communications systems to contact appropriate staff
1027 and authorities.

1028 Ms. Castor. So are you finding now in the surveys that they
1029 are adhering to the new requirements?

1030 Dr. Goodrich. So we are finding currently that there have
1031 been some providers that have been cited for noncompliance so
1032 we are working with them to bring them into compliance rapidly.

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1033 That is an area that they are required to adhere to. Currently,
1034 we are not finding that that is one of the most commonly cited
1035 deficiencies, but it is something that we are surveying for
1036 actively.

1037 Ms. Castor. Thank you. I mean states have a critical role
1038 here and I am concerned with certain states not following through
1039 with requirements. For instance, OIG's audits have found that
1040 some states fell short in investigating the most serious
1041 complaints in nursing homes. Ms. Dorrill, what are the
1042 nature of these complaints and what should we expect the states
1043 to do in response?

1044 Ms. Dorrill. The complaints ran across the board and then
1045 half of them were associated with high priority or immediate
1046 jeopardy, so serious complaints. And so I think the issue at
1047 hand is that states have to be held accountable. Dr. Goodrich
1048 talked a bit about that system and I think it's critical to all
1049 these pieces coming together that the states are understanding
1050 the new requirements and effectively enforcing those in the homes.

1051 Ms. Castor. Do you believe CMS is holding states
1052 accountable when they do not follow through with their
1053 responsibilities?

1054 Ms. Dorrill. So much of this is new, we'll certainly be
1055 looking at it. But so much of the new requirement in the guidance
1056 is just new within the last, you know, 9 months and so we don't
1057 know but we certainly have pointed out weaknesses. And we think

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1058 that it's a two-pronged approach. It's education and it's also
1059 ensuring that there's some kind of accountability on the part
1060 of the states to ensure that they follow through.

1061 Ms. Castor. Thank you. I yield back.

1062 Mr. Harper. The gentlewoman yields back. The chair will
1063 now recognize the gentleman from Virginia, the vice chairman of
1064 the subcommittee, for 5 minutes.

1065 Mr. Griffith. Thank you very much, Mr. Chairman. I greatly
1066 appreciate it.

1067 Dr. Goodrich, my colleagues, Congresswoman Black,
1068 Congressman Adrian Smith, Lujan and Crowley and I recently
1069 introduced the Reducing Unnecessary Senior Hospitalization Act
1070 of 2018 which seeks to improve quality in nursing homes by
1071 providing quality acute care at patients' bedsides via telehealth
1072 instead of transferring them to the hospital. By CMS' own
1073 calculations, two-thirds of hospital transfers are avoidable
1074 leading to increased costs to Medicare and negatively impacting
1075 health outcomes and quality of care. What are your thoughts
1076 on the potential for complementing current nursing home staff
1077 with emergency trained first responders utilizing telehealth to
1078 connect physician specialists, i.e., emergency physicians that
1079 might not otherwise be available to this patient population?

1080 Dr. Goodrich. So thank you for that question and letting
1081 me know about this pending legislation. So we do understand that
1082 as you mentioned transfers to the hospital that's, you know,

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1083 that's a very disrupting event for a nursing home patient and
1084 many of them are avoidable. This is something we actually measure
1085 as part of our quality reporting programs so we're certainly aware
1086 that there's a significant level of admissions to a hospital.

1087 So we would be very interested and willing to provide
1088 technical assistance to you and your staff on this legislation
1089 at your convenience.

1090 Mr. Griffith. Well, I appreciate that very much and thank
1091 you. You know, I am really excited by telemedicine.

1092 Representing a fairly rural district, I can tell you that one
1093 of my small nursing home chains has implemented wound care by
1094 using telemedicine, so they have a wound care specialist who is
1095 available.

1096 And one of their nurses will go in and see the patient who
1097 may have a bedsore or some other kind of injury and they are looking
1098 at through a pair of glasses that has a camera on it and the wound
1099 specialist wherever they are in the United States can see that
1100 wound, get a color picture, be able to then to tell the nursing
1101 home staff what needs to be done to make sure that that wound
1102 is being treated properly and taken care of. So I am really
1103 excited about telemedicine as a whole.

1104 Let me go to your payroll-based journal for staffing, because
1105 I do think that sometimes there may be some confusion. And while
1106 we recognize that we want the staffing to be there so you all
1107 can use it as a tool, you mentioned it in your statement, Mr.

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1108 Dicken mentioned in his that there was, you know, the
1109 self-reporting hadn't worked because there was a difference.

1110 But I think that may be a little unfair to CMS and to the
1111 nursing homes affected, to some of them. Not the bad actors but
1112 people that are really trying, because am I not correct that it
1113 is a slightly different standard? In self-reporting if you had
1114 a salaried employee who worked 50-55 hours a week they got to
1115 count that extra time, but under your report which I have no
1116 quarrel with, I am just saying they are different, you only count
1117 those folks at a maximum of 40 hours of being on the floor.

1118 Likewise, if you have an LPN who is doing supervisory work,
1119 they don't get credit for their supervisory time where an RN would.

1120 Again no quarrel with the change, but just saying that to say
1121 that the old reporting system was intentionally underreporting
1122 might not be fair since it is really apples to oranges. Wouldn't
1123 you agree with that?

1124 Dr. Goodrich. The previous reporting system was
1125 essentially a two-week snapshot that the nursing homes completed
1126 on a form during their recertification survey. The current
1127 system as you mentioned is based upon daily staffing levels of
1128 numerous different types of staff that the nursing homes have
1129 to report quarterly to CMS. And certainly as we were standing
1130 that up we had to make certain decisions around ensuring that
1131 what is reported is auditable back to the payroll so that it could
1132 be as it is required by law so that it could be as accurate as

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1133 possible.

1134 So the situations you mentioned around a salaried employee,
1135 yes, we only count the 40 hours a week that they would be working.

1136 Mr. Griffith. And I don't have any quarrel with that but
1137 to say that there was understaffing previously when you are using
1138 different metrics wouldn't really be fair to CMS or to some of
1139 the nursing homes. Wouldn't that be fair to say?

1140 Dr. Goodrich. I would say it's very difficult to compare
1141 the two.

1142 Mr. Griffith. Difficult to compare, okay.

1143 The Commonwealth of Virginia partnering with healthcare
1144 providers developed a long-term care mutual aid plan which is
1145 a voluntary agreement among participating nursing homes that they
1146 will share supplies, resources, and house residents from other
1147 facilities if a serious need arises. We heard Chairman Walden
1148 say earlier that one of his nursing homes or a small chain had
1149 a facility in California and was looking to move patients to
1150 Oregon. This is actually a statewide system. Are you
1151 familiar with this type of plan and do you think it will work
1152 and do you think other states will adopt it?

1153 Dr. Goodrich. I am not familiar with this kind of plan but
1154 we certainly would be interested to learn more and again our staff
1155 would be glad to follow up with you on this.

1156 Mr. Griffith. Very good. Thank you so much.

1157 I yield back, Mr. Chairman.

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1158 Mr. Harper. The gentleman yields back. The chair will now
1159 recognize the gentleman from California, Mr. Ruiz, for 5 minutes.

1160 Mr. Ruiz. Thank you, Mr. Chairman. Taking care of seniors
1161 has been a big priority for me as a physician. I am an emergency
1162 medicine doctor, Dr. Goodrich, and now as a Member of Congress
1163 advocating for them here. And when a loved one is placed in the
1164 care of a nursing home, we trust and expect that they will receive
1165 high quality care and as we know many nursing homes do exactly
1166 that. But it is also clear from years of reports from OIG and
1167 GAO that there are problematic providers out there.

1168 Ms. Dorrill, your office did groundbreaking work that
1169 identified instances of adverse events in nursing homes and you
1170 found that one in three Medicare beneficiaries experienced harm
1171 during their stay. So what kind of adverse events did these
1172 residents experience, can you elaborate on those?

1173 Ms. Dorrill. Yes, thank you for the question. It really
1174 ranged the gamut. And that's actually a part of our message is
1175 that we found that nursing homes were focusing on just a small
1176 number of events, falls with injury, for example, and pressure
1177 ulcers, and they were excluding a broad range of events that were
1178 already happening that went unnoticed as harm. Things like blood
1179 clots and dehydration that can seem like subtle --

1180 Mr. Ruiz. That they didn't identify and allowed it to
1181 persist for a time. How about medical errors, giving the wrong
1182 medication, et cetera?

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1183 Ms. Dorrill. Fourteen percent of our events involve medical
1184 error. When a lot of people think about adverse events they think
1185 it's all medical error. But one of the things that we've tried
1186 to promulgate is this notion that adverse events can occur from
1187 general substandard care. It's not really a mistake, it's just
1188 not doing the right thing.

1189 Mr. Ruiz. So you say that half of these were preventable.
1190 Can you give me some examples of those that were not preventable
1191 that --

1192 Ms. Dorrill. Yes. So, for example, if someone was given
1193 a medication and they were allergic to that and had a reaction
1194 but no one knew that they were allergic that was not information
1195 that the physician could have acted upon.

1196 Mr. Ruiz. And so are these different adverse events not
1197 on the state agencies' survey lists? Why are they not looking
1198 for these?

1199 Ms. Dorrill. I think that there's been a revolution and
1200 this is true for hospitals too in the whole notion of adverse
1201 events. And CMS has changed its hospitals provisions as well
1202 that I think there was just a narrow focus on a small number of
1203 events and people weren't thinking about harm more broadly.

1204 Mr. Ruiz. So they weren't.

1205 Ms. Dorrill. No.

1206 Mr. Ruiz. They weren't looking for these different types
1207 of adverse events.

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1208 Ms. Dorrill. That's correct.

1209 Mr. Ruiz. So I would like to turn to another quality of
1210 care concern. In your recent reporting, OIG again identified
1211 Medicare beneficiaries in nursing homes who suffered harm, this
1212 time from abuse and neglect, where still OIG found that, quote,
1213 a significant percentage of these incidents may not have been
1214 reported to law enforcement.

1215 So I find this very troubling and so did you, or OIG, enough
1216 to issue an early alert to CMS about the findings. What are some
1217 of the immediate actions CMS can take to address these
1218 vulnerabilities?

1219 Ms. Dorrill. Thank you. We first requested that they do
1220 what we did which is it's possible to look in the claims and find
1221 out a lot of these things are claims associated with abuse and
1222 neglect and that we suggested that CMS do that to monitor the
1223 situation. And then, secondly, we also suggested that they
1224 enhance their pursuit of the authority to be able to give remedies
1225 when these events were not reported.

1226 Mr. Ruiz. Dr. Goodrich, what has the agency taken, what
1227 actions has the agency taken to address this finding?

1228 Dr. Goodrich. So regarding the recommendation to look in
1229 the claims for emergency room services and matching those claims
1230 to skilled nursing facilities, that is something that we are
1231 currently exploring the feasibility of doing.

1232 Mr. Ruiz. You haven't started it but you are just looking

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1233 into it.

1234 Dr. Goodrich. We're exploring whether or not that's
1235 feasible to do to be able to have that information to the
1236 surveyors.

1237 Mr. Ruiz. Well, by law, as an emergency physician if
1238 somebody reports any suspicion of abuse or neglect that has to
1239 go into the medical record and that has to be reported to the
1240 county officials and APS and all that so that would be a good
1241 place to start.

1242 I have another question in terms of empowering the clients
1243 and consumers and also their families. Is there any requirement
1244 that when a patient gets or a person gets admitted to a nursing
1245 home during the orientation that they are given an understanding
1246 of their rights, of quality measures, resources, to understand
1247 more about what those quality measures are and also a way to report
1248 any concerns to a third party like an agency or CMS, is that a
1249 requirement, part of your requirements for CMS so that they know
1250 that and is that being implemented properly?

1251 Dr. Goodrich. Yes. So yes, that is a requirement as part
1252 of our requirements for participation that residents or their,
1253 and their families or their surrogates be informed of their rights
1254 as soon as they are admitted into a nursing facility and that
1255 they are informed of their rights to file complaints with the
1256 state survey agency or with law enforcement.

1257 Mr. Ruiz. Are they given the information on how to do that?

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1258 Dr. Goodrich. Yeah, it's supposed to be posted in the
1259 nursing home. Sorry, I'm not familiar with the details.

1260 Mr. Ruiz. Yes, see that is the difference that Ms. Dorrill
1261 was saying. It is either posted or you have something in writing,
1262 but the true understanding and the implementation of that
1263 information is a different story.

1264 So do we know if it is being conducted in a way where during
1265 the orientation they are being explained on how to file a
1266 complaint?

1267 Dr. Goodrich. Yes. As part of the admission process in
1268 addition to everything about the plan of care in clinical care,
1269 one of our conditions or requirements for participation is around
1270 patient rights and being informed of those rights.

1271 Mr. Ruiz. Thank you.

1272 Mr. Harper. The gentleman yields back. The chair will now
1273 recognize the gentlewoman from Indiana, Mrs. Brooks, for 5
1274 minutes.

1275 Mrs. Brooks. Thank you, Mr. Chairman, and thank you for
1276 holding this very important hearing.

1277 Ms. Dorrill, I would like as Chairman Harper talked about
1278 in his opening statement, I want to focus a little bit on my line
1279 of questioning regarding the owner of the facility where the 12
1280 residents died in the aftermath of Hurricane Irma, the Hollywood
1281 Hills. Because it is my understanding that Dr. Michel -- is
1282 that how we say his name, or Michel? Is it Michel? Michel --

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1283 had been the subject of wrongdoing in the past including settling
1284 with the Department of Justice long ago, corporate integrity
1285 agreement, after being implicated in a scheme to receive kickbacks
1286 for providing unnecessary medical treatment to elderly residents
1287 and that was the '06 timeframe.

1288 Can you please explain -- and I am a former U.S. Attorney
1289 so I have worked with HHS OIG. Can you explain what tools are
1290 available to you to exclude facility owners from owning nursing
1291 homes if obviously OIG had determined and there was a settlement
1292 and so forth, but they were involved in participating in this
1293 unlawful conduct or fraud, can you go into deeper detail about
1294 exclusion process?

1295 Ms. Dorrill. Yes, just to say though, you know, I'm not
1296 in the Counsel's Office. I'm not an investigator but I'll do
1297 my best, that OIG has a number of tools at our disposal and this
1298 it's critical to us. It's the main part of our work that we hold
1299 wrongdoers accountable. And so I think the important thing to
1300 remember is that those tools are at our disposal and that it
1301 depends on the specific facts and circumstances of the case what
1302 direction we go.

1303 But we certainly have the exclusion authority. We also have
1304 tools such as under the False Claims Act we have the ability to
1305 impose civil monetary penalties. We also have hundreds of
1306 criminal investigators who help their law enforcement partners
1307 to investigate criminal cases. So it's a broad range of activity

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1308 and core to our mission.

1309 Mrs. Brooks. Can you talk a little bit though about the
1310 exclusion authority tool and how long the process takes, who
1311 ultimately makes the decision as to when a provider is on the
1312 exclusion list?

1313 Ms. Dorrill. So for those who may not be familiar and again
1314 I'm not in the Counsel's Office, but the OIG can exclude
1315 individuals and entities from federal programs such as Medicare
1316 and Medicaid for various types of conduct set forth in statute
1317 including false claims. The primary effect of that exclusion
1318 is it will no longer pay for services and we maintain a database
1319 with all that information publicly. OIG has certainly
1320 excluded nursing home providers. We recently excluded a
1321 13-facility nursing home chain. We have something like 70,000
1322 excluded providers now, something like 1,600 just this fiscal
1323 year alone. So I don't know if that fully answers your question.

1324 Mrs. Brooks. It doesn't require though a criminal
1325 conviction then for a person to be excluded or an entity to be
1326 excluded?

1327 Ms. Dorrill. I'll need to take that question, I'd be so
1328 happy to, back to my Counsel's Office to make sure that I can
1329 give you accurate information there.

1330 Mrs. Brooks. I think we would like to know more information
1331 about the exclusion process from Counsel's Office and from your
1332 office particularly relative to, you know, not only we had that

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1333 incident, but as I understand there are other incidents involving
1334 this particular provider let alone the Hollywood Hills incident.

1335 So I am interested in knowing how long the process takes, who
1336 makes the final decisions, what are the categories that a person
1337 can be excluded.

1338 Then I would like to ask both you and Dr. Goodrich a little
1339 bit more about the emergency preparedness issues. We are
1340 reauthorizing what is called PAHPA, Pandemic All-Hazards
1341 Preparedness Act, and we are including in that a provision to
1342 have the National Academy of Medicine do an overview of emergency
1343 preparedness by hospitals but also long-term care facilities.

1344 And because as I am hearing you both say that while there might
1345 be plans in place that doesn't necessarily mean the execution
1346 of those plans happen.

1347 And is that any -- do you believe there needs to be more
1348 attention to this emergency preparedness that we are not doing
1349 enough? Dr. Goodrich?

1350 Dr. Goodrich. Thank you. Obviously this is, you know, a
1351 huge priority for us especially given the events of last year.

1352 So as we've mentioned we are in the process, in the early process
1353 of implementing that regulation and surveying facilities for
1354 that. So as you're working, doing your work on this area we'd
1355 be more than happy to give you technical assistance and talk
1356 through these issues with you. But we are early in the process
1357 and I think learning how it is going.

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1358 Mrs. Brooks. Okay, thank you.

1359 Ms. Dorrill, anything further before my time is expired?

1360 Ms. Dorrill. No, just asserting that we found significant
1361 problems with the emergency planning and appreciate your focus
1362 on that areas.

1363 Mrs. Brooks. Thank you. I yield back.

1364 Mr. Harper. The gentlewoman yields back. The chair will
1365 now recognize the gentlewoman from Illinois, Ms. Schakowsky, for
1366 5 minutes.

1367 Ms. Schakowsky. Thank you, Mr. Chairman.

1368 If I sound a little impatient about this focus on nursing
1369 home and safety it is because I have been working on this issue
1370 since the mid-80s, including when I was in the state legislature
1371 in Illinois and ever since I have been here in Congress. There
1372 are some provisions in the Affordable Care Act that deal with
1373 nursing homes that I was successful in getting into the
1374 legislation. But I don't know how many GAO reports there have
1375 been. I don't know how many reports from oversight committees
1376 there have been about these persistent problems.

1377 And as we enter into this age where more, you know, the aging
1378 of America, the graying of America, more and more people needing
1379 long-term care including nursing homes, it is hard for me to hear
1380 words like, this is an important first step. I mean we need to
1381 be making last steps now. We need to be getting at the heart
1382 of the problem.

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1383 Let me ask you, Dr. Goodrich, who has the primary
1384 responsibility to make sure that nursing home quality standards
1385 are met, states or CMS? And is it the policy of the Trump
1386 administration to shift more of the responsibility to the states?

1387 Dr. Goodrich. So it is a shared responsibility between the
1388 states and CMS. We promulgate the regulations and then we oversee
1389 the state survey agencies in their implementation of the surveys
1390 of the nursing homes and the implementation of those regulations.

1391 And as I --

1392 Ms. Schakowsky. Are we seeing more of a shift towards states
1393 or is this always standard?

1394 Dr. Goodrich. Our process for overseeing health and safety
1395 for nursing homes remains the same. It hasn't changed. It
1396 remains a partnership in the way that I just described.

1397 Ms. Schakowsky. What was the rationale behind no longer
1398 imposing financial penalties for each day of a violation?
1399 Couldn't that be seen as a weakening of a commitment to
1400 enforcement?

1401 Dr. Goodrich. Specifically related to the civil monetary
1402 penalties what we were seeing over the last few years and what
1403 had been, I think, also recognized by others was that there was
1404 quite a bit of variation in how civil monetary penalties were
1405 being applied across the country. In some areas not being applied
1406 enough when they should have been and in other areas being applied
1407 in situations when actually should have had different enforcement

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1408 remedies applied.

1409 So we sought to make that process more standardized and more
1410 uniform so that there was consistency across the country in the
1411 correct application of civil monetary penalties. And so last
1412 year what we did was we worked with the regional offices and we
1413 developed a civil monetary penalty tool so that survey agencies
1414 and our regional offices could go and use that tool which has
1415 essentially an algorithm in it to ensure that regions are
1416 consistently and accurately applying civil monetary penalties.

1417 Ms. Schakowsky. Except that I am asking about the penalties
1418 then, not the monitoring, the penalties, no longer imposing
1419 financial penalties for each day.

1420 Dr. Goodrich. So we do still impose financial penalties
1421 for each day, so per day penalties depending upon the
1422 circumstance. And the number of those penalties has actually
1423 risen over the last 4 years. In 2014 we had just over 1,100 per
1424 day civil monetary penalties and in 2017 we had almost 2,000 per
1425 day.

1426 Ms. Schakowsky. So let me ask you this. Do the nursing
1427 home advocates support these changes?

1428 Dr. Goodrich. We have certainly worked with and been
1429 transparent about our intents here related to --

1430 Ms. Schakowsky. That is kind of a yes or no.

1431 Dr. Goodrich. I would have to ask the nursing home
1432 advocates. We certainly have had discussions with them about

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1433 this. We have seen --

1434 Ms. Schakowsky. My understanding is no. Let me also, I
1435 want to get to a Human Rights Watch report found that in an average
1436 week nursing facilities in the United States administer powerful
1437 anti-psychotropic drugs in over 179,000 people who don't need
1438 them. I ask unanimous consent to enter that report into the
1439 record.

1440 Mr. Harper. Without objection.

1441 [The information follows:]

1442

1443 *****COMMITTEE INSERT 4*****

1444 Ms. Schakowsky. These drugs are often given without
1445 informed consent. This is after a 2011 OIG report that found
1446 rampant overuse of these anti-psychotic drugs.

1447 So, Dr. Goodrich, what actions are CMS taking to address
1448 the high rate of these drugs and used 7 years after that OIG report?

1449 Dr. Goodrich. So we would completely agree that this has
1450 been a very significant quality and safety issue within nursing
1451 homes. That is why in 2011 in partnership with a number of
1452 stakeholders we launched the National Partnership to Improve
1453 Dementia Care in Nursing Homes which was a holistic effort around
1454 dementia care, but definitely had a very serious focus around
1455 reducing inappropriate use of anti-psychotics in nursing homes.

1456 We have seen over that time period from 2011 to early 2017
1457 a 34 percent reduction in the inappropriate use of anti-psychotics
1458 and we are now focusing --

1459 Ms. Schakowsky. So two-thirds still remains.

1460 Dr. Goodrich. So there is still overuse. That is true.

1461 And there are particular nursing homes in the country who have
1462 not made the kinds of improvements that we would hope. And so
1463 we have set a new goal to focus on those facilities that are still
1464 overusing to unacceptable extent.

1465 Ms. Schakowsky. Thank you.

1466 Mr. Harper. The gentlewoman yields back. The chair will
1467 now recognize the gentlewoman from California, Mrs. Walters, for
1468 5 minutes.

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1469 Mrs. Walters. Thank you, Mr. Chairman. Federal
1470 regulations enumerate a limited number of circumstances under
1471 which a nursing facility or skilled nursing facility may transfer
1472 or discharge a resident against their will. Under federal law,
1473 a nursing facility or skilled nursing facility must also readmit
1474 residents who may temporarily leave for a hospitalization.
1475 However, claims that nursing home residents are being dumped or
1476 denied readmission appears to be a growing concern.

1477 For example, according to press reports, the California
1478 State Long-term Care Ombudsman received more than 1,500
1479 complaints in 2016 alleging that residents have been improperly
1480 discharged or evicted from nursing homes in California. This
1481 is a 73 percent increase from the number of complaints received
1482 since 2011. The Illinois State Ombudsman has stated that such
1483 complaints have more than doubled since 2011.

1484 Dr. Goodrich, does CMS view involuntary discharges of
1485 nursing home residents or denials of readmission as a significant
1486 problem?

1487 Dr. Goodrich. Yes. This is something that we have also
1488 heard reports about happening and it is something that we're
1489 concerned about absolutely.

1490 Mrs. Walters. When nursing homes residents are
1491 involuntarily discharged from or denied readmission to a nursing
1492 home after a hospital stay, where do they typically end up and
1493 how are they cared for?

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1494 Dr. Goodrich. So I think that's variable and that is
1495 something that we are trying to explore a little further to
1496 understand what's happening on the ground with these residents.

1497 So certainly where they end up if that's your question can be
1498 quite variable. It can be, you know, with a family member and
1499 another facility is often where they will end up going as well.

1500 Mrs. Walters. Are you guys trying to do any sort of analysis
1501 on this to find out exactly where they are ending up?

1502 Dr. Goodrich. I'd be happy to get back to you with the answer
1503 to the question to how we're taking a look at that. I'm not sure
1504 of the specifics.

1505 Mrs. Walters. Did you want to add something?

1506 Ms. Dorrill. We have, we're currently underway on this
1507 exact issue. I share your concern and we have a study that will
1508 be coming out shortly that will be of interest to you.

1509 Mrs. Walters. Okay, thank you.

1510 Federal law also requires states provide nursing home
1511 residents, who allege they were improperly discharged or
1512 transferred, with a hearing and, if appropriate, provide for
1513 residents a readmission to the nursing home if they prevail.
1514 However, it has been alleged that California is failing to enforce
1515 its own hearing decisions in instances where decisions have been
1516 rendered in favor of residents.

1517 In a 2012 letter to the California Department of Public
1518 Health, Center for Healthcare Quality, CMS stated that while it

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1519 could not advise California what particular state agency should
1520 enforce the hearing decisions, as that is for the states to decide,
1521 CMS regulations are clear that the state agency must promptly
1522 make corrective actions. CMS reiterated California's obligation
1523 to enforce its hearing decisions in a letter sent on August 31st,
1524 2017.

1525 Dr. Goodrich, how does CMS verify that states are fulfilling
1526 their legal obligations to adjudicate and enforce hearing
1527 decisions related to improper nurse home discharges or transfers?

1528 Dr. Goodrich. So this is a topic with which I'm not terribly
1529 familiar of the specifics of the California case, but we'd be
1530 very happy to take a look at it and get back to you with responses
1531 to that.

1532 Mrs. Walters. Okay, so then I don't know if you can answer
1533 these two questions but I will ask you. Does CMS know whether
1534 California is meeting its legal obligations to enforce these
1535 decisions?

1536 Dr. Goodrich. I'm not personally aware but we will get back
1537 to you with that.

1538 Mrs. Walters. Okay, then I have one more. Does CMS know
1539 of or have reason to believe other states may be failing to enforce
1540 their hearing decisions?

1541 Dr. Goodrich. I think that's something we certainly would
1542 be concerned about and would be happy to get back to you with
1543 responses.

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1544 Mrs. Walters. Okay, if you guys could follow up --

1545 Dr. Goodrich. We will.

1546 Mrs. Walters. -- and get back to the committee on that
1547 we would really appreciate it.

1548 Dr. Goodrich. Of course.

1549 Mrs. Walters. Thank you and I yield back the balance of
1550 my time.

1551 Mr. Harper. The gentlewoman yields back. I will now
1552 recognize the vice chairman of the subcommittee, Mr. Griffith,
1553 for the purposes of a follow-up question.

1554 Mr. Griffith. Yeah, and I think that Ms. Schakowsky and
1555 I might be on the same side, we might not be, but it deals with
1556 the daily fines and so forth. Because I am aware of a situation,
1557 so I am glad you are looking at it so we can get these algorithms
1558 where they make sense because you want to punish people for bad
1559 acts.

1560 But I am aware of a situation where coffee was spilled.
1561 There was an incident. Something should have been said but
1562 somehow the fine ended up being between a million and two million
1563 dollars. The patient never went to the hospital. No serious
1564 injuries. Clearly something needed to be done, but it seemed
1565 that maybe the old algorithm was a little out of whack if you
1566 end up with a million to two million dollar penalty for spilled
1567 coffee and no hospitalization.

1568 Dr. Goodrich. So I'm not familiar with that particular

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1569 incident, but I think that is potentially an example where there
1570 was again as I mentioned before we weren't always seeing
1571 consistent application of the civil monetary penalties in both
1572 directions. And so that's why we really have been trying to
1573 standardize that.

1574 Mr. Griffith. And I appreciate that and hope that you all
1575 get that all worked out, but agree that there ought to be penalties
1576 and there ought to be something that the nursing homes can know
1577 that this is what we are supposed to do, and if there is a problem
1578 the penalty will be something that is equal to or in the vein
1579 of what ought to be happening.

1580 Thank you, yield back.

1581 Mr. Harper. The chair will now recognize Ms. Schakowsky
1582 for the purposes of a follow-up question.

1583 Ms. Schakowsky. So in terms of CMS enforcement I wondered
1584 how you are using these new -- we have been talking somewhat
1585 about the payroll staffing data reported by nursing homes to
1586 enforce the requirements that each facility have a registered
1587 nurse on duty at least 8 hours every day. Let me just state my
1588 preference. I mean I think most people who put a person in a
1589 nursing home would be shocked that there is not a nurse, a
1590 registered nurse 24/7, you know, when they get the bill for the
1591 month that there is not a nurse there.

1592 I have a piece of legislation I have introduced, Put a Nurse
1593 in a Nursing Home. But I am just wondering how you are following

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1594 up on that.

1595 Dr. Goodrich. Absolutely. Thank you for bringing that up.

1596 We would agree that the new payroll-based journal system gives
1597 us really unprecedented insight into staffing within nursing
1598 homes. And as you mentioned, some of the things that we have
1599 discovered since we started requiring the reporting of those data
1600 is exactly what you mentioned, is that there are some nursing
1601 homes that do not have a registered nurse as required by our
1602 regulations for 8 hours a day, 7 days a week. And I think
1603 even more concerning is that we see fluctuations in some nursing
1604 homes, again a minority but it's there, where that those
1605 deficiencies in nurse staffing are more common on the weekends
1606 than they are on the weekdays. And I can't think of any clinical
1607 reason why that should be different on a Saturday than on a
1608 Tuesday.

1609 So that is something that we are concerned about and right
1610 now we're taking two actions related to that. I will caveat that
1611 by saying this is early, we're exploring the data and we're
1612 thinking ahead about other ways in which we can use these data
1613 better. So number one, one thing we have already done is in the
1614 five-star rating system nursing homes that do not have nurse
1615 staffing as appropriate for at least 7 days out of a quarter,
1616 their star rating goes down to one star and that affects the
1617 staffing star rating and that affects that overall star rating
1618 as well.

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1619 We are also looking at ways in which we could incorporate
1620 the findings that I just mentioned about the fluctuations and
1621 the lack of nursing as required by regulation further into the
1622 star rating system. The second thing that we're doing is that
1623 we are embedding the data, the staffing data into our survey
1624 software which will then allow the state surveyors when they go
1625 onsite to do their investigations to have that information around
1626 staffing for that nursing home that they are in so that they can
1627 look for quality issues that may be related to staffing based
1628 upon the data they have right there in their hand.

1629 So those are two ways in which we're, for now, initially
1630 using these data, but we'll continue to explore other ways.

1631 Ms. Schakowsky. Okay, and any of the other two witnesses
1632 want to say anything on this topic? I don't know.

1633 Ms. Dorrill. I just wanted to say that we have work underway
1634 now on the payroll-based journal and we plan to look at the
1635 accuracy of the data and CMS' use of it at this early
1636 implementation.

1637 Ms. Schakowsky. Okay. I would really like to see that
1638 after you complete your investigation of that issue. So good,
1639 thank you very much. I yield back.

1640 Mr. Harper. The chair will now recognize the gentleman,
1641 in celebration of his birthday, the gentleman from Georgia, Mr.
1642 Carter.

1643 Mr. Carter. Thank you, Mr. Chairman. I appreciate you

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1644 sharing that with everyone. And I do appreciate it very much.

1645 Mr. Harper. We didn't ask what year.

1646 Mr. Carter. You can't thank me for that as well, yeah.

1647 Well, thank all of you for being here. Full disclosure,
1648 I am currently the only pharmacist serving in Congress. Not only
1649 am I a pharmacist, but I was also a consultant pharmacist and
1650 my expertise and my career was spent in institutional pharmacy
1651 in nursing homes. I have gone through federal inspections, state
1652 inspections, so this is something that I am very familiar with.

1653 And I have to tell you I was blessed to be in a number of
1654 good nursing homes that provided quality care that really cared
1655 about the patients and sometimes I could be frustrated by some
1656 of the regulations. And I just want to encourage you, a couple
1657 of things. First of all, you know, it is important and it is
1658 important to have a registered nurse 8 hours a day. It is
1659 important to make sure that rules and regulations are followed,
1660 but sometimes we get caught up in the cookie cutter approach that
1661 one size fits all.

1662 And I just want to encourage you and I say that because I
1663 have seen it firsthand. I have seen how nursing homes struggle
1664 and they struggle to find good quality help. They don't pay very
1665 high, they can't afford to. It is difficult at times. That is
1666 no excuse, you still have to have quality care and as I say I
1667 was very blessed to be in facilities that provided quality care.

1668 I think that you have -- I am sorry I had another hearing,

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1669 but we have already talked about the payroll-based journal and
1670 about the fact that salaried employees, and trust me, I have seen
1671 a salaried, a DNS who has, you know, is registered as 40 hours
1672 seeing a more 60 or 80 hours a week. So that is kind of a misnomer
1673 and I hope you take that into consideration.

1674 And then whenever, you know, you are talking about a
1675 30-minute lunch break, I have seen them, you know, take 5 minutes
1676 to cram something in their mouth and go on and continue on. I
1677 have also seen it as you well know, and I know I am the preacher
1678 preaching to the choir here, but nursing homes can fall apart
1679 quickly. I have been in a nursing home in the morning and it
1680 was, you know, in top shape and then by the afternoon and just
1681 because of the patient population it can really fall apart very
1682 quickly. But anyway, having said that I will tell you that
1683 I am concerned particularly the federal inspectors as it relates
1684 to the state inspectors. I have seen the state inspectors
1685 sometimes try to do too much because the federal inspectors are
1686 following them. Generally what happens is that you would always
1687 know if the fire inspector came and then probably the surveyors,
1688 the state surveyors were coming next because the fire inspector
1689 would always come first and then the state surveyors would come.

1690 And the federal surveyors would come after the state
1691 surveyors in order to see how well the state surveyors had done
1692 and sometimes I felt like they were putting undue pressure on
1693 some of the state inspectors. Not that they didn't need it at

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1694 times, they did, and it is important. It is important to have
1695 the checks and balances in that and I understand that.

1696 I wanted to ask you and I will ask Dr. Goodrich, you, this
1697 question about some of the potential complexity for providers
1698 that have that the regulations. As I understand it, there has
1699 been a temporary moratorium placed on some of the 194 regulations
1700 as a result of the stakeholder feedback. Just to clarify, how
1701 many of the 194 regulations had this moratorium placed on them?

1702 Dr. Goodrich. Eight.

1703 Mr. Carter. Eight of them. And out of those eight did any
1704 of those have to do with neglect or with abuse?

1705 Dr. Goodrich. They did not.

1706 Mr. Carter. They did not, okay. Good, they should not and
1707 I appreciate that. And, finally, do facilities still have to
1708 enforce these eight regulations and have a plan in place to fix
1709 them if they are noncompliant?

1710 Dr. Goodrich. Absolutely. That's our expectation, yes.

1711 Mr. Carter. That is your expectation, good. Again you
1712 know, I have seen the burden that can be placed on these facilities
1713 and again no one is accepting and I am certainly not advocating
1714 that they shouldn't have quality care. This is a very feeble,
1715 if you will, population that needs this help. But I just want
1716 to make sure we have balance here. I want you to understand that
1717 I have worked side by side with these people in the nursing homes
1718 and they are good people who truly -- for the most part.

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1719 Now like every profession you have bad actors and you have
1720 to get rid of those bad actors and to a certain extent, to a large
1721 extent that is your responsibility and the responsibility of the
1722 state surveyors. We need to get those bad actors out. They need
1723 to be brought to justice, if you will. But for the most part,
1724 I want you -- I just feel like I need to express to you the
1725 true quality work that many of these facilities provide and that
1726 many of these employees provide. And, Mr. Chairman, I will yield.

1727 Mr. Harper. The gentleman yields back. The chair will now
1728 recognize the gentleman from Florida, Mr. Billirakis, for 5
1729 minutes.

1730 Mr. Bilirakis. Thank you, Mr. Chairman. I appreciate it.
1731 Thanks for holding this hearing, so very important.

1732 As you know, Mr. Chairman, last year we had Irma that hit
1733 Florida. The many hardworking staff of our nursing homes and
1734 assisted living facilities prepared for the hurricane, 862
1735 facilities evacuated, over 2,000 facilities lost power in the
1736 state of Florida. They were tested by the storm and the vast
1737 majority passed. Again those folks were doing the Lord's work
1738 and we do appreciate them so very much.

1739 Yet, in every group there are bad actors as my colleague
1740 just said. We had the Rehabilitation Center at Hollywood Hills
1741 fail to take the proper measures to protect their residents and
1742 as a result 12 people died from heat exposure despite having a
1743 hospital across the street from the facility. These deaths were

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1744 100 percent preventable.

1745 One of the concerns that have is how many facilities are
1746 not in compliance with the emergency rule. Dr. Goodrich, I
1747 believe that CMS began compliance surveys last year. That is
1748 my understanding. Do we know how many facilities are currently
1749 not in compliance with the emergency rule? That is my first
1750 question.

1751 Dr. Goodrich. Certainly. So we are about 75 percent of
1752 the way through surveying all facilities nationally for the
1753 emergency preparedness requirements. We will have completed
1754 surveys for a hundred percent of facilities by February of 2019.

1755 While we are finding that the majority of facilities are in
1756 compliance or come into compliance quickly, we have had some
1757 citations for noncompliance that are intended to swiftly bring
1758 these facilities into compliance. So we have had about
1759 2,300 facilities or so, so far, be cited for noncompliance that
1760 then would have to implement a corrective action plan in order
1761 to come into compliance.

1762 Mr. Bilirakis. So 2,300 out of how many?

1763 Dr. Goodrich. There's a total of about 15,600 nursing homes
1764 but again they haven't all been surveyed yet.

1765 Mr. Bilirakis. Right, so but the majority of them have been
1766 surveyed.

1767 Dr. Goodrich. Seventy five percent about.

1768 Mr. Bilirakis. Okay, thank you. The rehab center had their

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1769 provider agreement terminated. This is the one that I was
1770 speaking of in Hollywood, Florida. It was terminated by CMS.

1771 Despite this, the owner of the rehab center still has an ownership
1772 stake in 11 other facilities that participate in the Medicare
1773 program. These facilities continue to operate despite the
1774 tragedy that occurred last year and the previous allegations that
1775 the Department of Justice made against the owner regarding
1776 providing unnecessary medical treatment to seniors.

1777 Dr. Goodrich, given your experience at CMS, are you surprised
1778 by this that there are so many, he is operating so many other
1779 facilities? And yes and is he being monitored? Can you maybe
1780 expand on that, please?

1781 Dr. Goodrich. Certainly. So for any Medicare-certified
1782 facility of any type they are required to undergo surveys just
1783 like nursing homes do, so whatever type of facility an owner may
1784 have an ownership interest in. So they have to undergo periodic
1785 recertification surveys in the situation of nursing homes, those
1786 are annual. And then there's complaint surveys that can take
1787 place if somebody files a quality of care complaint.

1788 So any facility no matter what type that is
1789 Medicare-certified would have to undergo these surveys as well.

1790 Mr. Bilirakis. Okay, can you maybe get back to me on whether
1791 these other 12 facilities that this person owns follow the
1792 emergency rule? Can you give me that information? I know you
1793 can't, more than likely you don't have it with you now.

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1794 Dr. Goodrich. What I do know is that the other facilities
1795 owned by this owner have undergone the standard recertification
1796 surveys. As it relates specifically to emergency preparedness
1797 we will have to get back to you on that.

1798 Mr. Bilirakis. Please get back to me on that. I appreciate
1799 it. Again, Doctor, I know the state is trying to pull the rehab
1800 center's owners licenses, but I am told it is tied up in the court
1801 system at the moment. I know I don't have a lot of time, so can
1802 CMS terminate the provider agreements with the various facilities
1803 that he has an ownership stake in? Do you have the ability to
1804 do that?

1805 Dr. Goodrich. As I understand it, Medicare has the ability
1806 to bar an individual from owning other facilities under two
1807 circumstances. One is if they have a felony conviction and the
1808 second is if they're on the OIG exclusion list.

1809 Mr. Bilirakis. Okay, very good.

1810 Well, thank you, Mr. Chairman. Thanks for allowing me to
1811 sit in and thanks for holding this hearing. I appreciate it.

1812 Mr. Harper. The gentleman yields back.

1813 Just a little quick follow-up to you, Ms. Dorrill, and to
1814 you, Mr. Dicken. Both HHS OIG and GAO have found situations where
1815 these allegations of abuse or neglect or substandard care they
1816 have been reported but state survey agencies failed to investigate
1817 those claims in a timely manner. CMS reserves immediate jeopardy
1818 classifications for situations that have caused or are likely

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1819 to cause a serious injury, harm, or death to a resident and require
1820 such a claim to be investigated within 2 days.

1821 So, Ms. Dorrill and Mr. Dicken, when state survey agencies
1822 fail to conduct those timely investigations especially in cases
1823 of immediate jeopardy, does that place nursing home residents
1824 at greater risk?

1825 Mr. Dicken. Certainly as we've looked at the complaint
1826 investigation processes we've seen that states have sometimes
1827 been challenged to meet timeframes better at the immediate
1828 jeopardy types of issues that you raise. We did see, however,
1829 that as states are not timely it's much more difficult for states
1830 to be able to substantiate allegations and there are higher
1831 substantiation when they are meeting timely frameworks. So it
1832 is important to have a timely and complete complaint
1833 investigation.

1834 Mr. Harper. All right. Well, let me follow up on that.
1835 So does this failure also potentially allow facilities which
1836 may have in fact harmed a resident to go unpunished and perhaps
1837 give a false impression that they are providing a better standard
1838 of care than they actually are?

1839 Mr. Dicken. Well, certainly to the extent that the
1840 complaints are not investigated or not investigated in a timely
1841 manner that as you know can make it hard to substantiate.
1842 Certainly there are other processes that can go in and identify
1843 that as part of the standard survey process, but that is a real

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1844 concern that if they are not being substantiated and because of
1845 not timely reviews.

1846 Mr. Harper. Thank you.

1847 Ms. Dorrill, anything you would like to add to that?

1848 Ms. Dorrill. Just to reiterate how important timeliness
1849 is in terms of substantiation. We did find that there were only
1850 a handful of states who had substantial problems with that to
1851 the extent that that's helpful.

1852 Mr. Harper. I want to thank each of you for being here.

1853 Our concern is the care and well-being of the residents of any
1854 of these facilities. They are the loved ones of many families
1855 that care greatly about what happens. You have a great
1856 responsibility. We thank you for being here today.

1857 I also want to remind members that they have 10 business
1858 days to submit questions for the record, and should you receive
1859 any of those as witnesses from today we would appreciate your
1860 response as promptly as possible to that. With that the
1861 subcommittee is adjourned.

1862 [Whereupon, at 12:00 p.m., the subcommittee was adjourned.]

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