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Congress of the United States House of Representatives

COMMITTEE ON ENERGY AND COMMERCE 2125 RAYBURN HOUSE OFFICE BUILDING WASHINGTON, DC 20515-6115

> Majority (202) 225-2927 Minority (202) 225-3641

MEMORANDUM

September 4, 2018

To: Subcommittee on Oversight and Investigations Democratic Members and Staff

Fr: Committee on Energy and Commerce Democratic Staff

Re: Hearing on "Examining Federal Efforts to Ensure Quality of Care and Resident Safety in Nursing Homes"

On <u>Thursday</u>, <u>September 6</u>, <u>2018</u>, <u>at 10:15 a.m.</u> in room <u>2322 of the Rayburn House Office Building</u>, the Subcommittee on Oversight and Investigations will hold a hearing entitled "Examining Federal Efforts to Ensure Quality of Care and Resident Safety in Nursing Homes." The hearing will examine the Centers for Medicare & Medicaid Services' (CMS) regulation and oversight of nursing homes participating in the Medicare and Medicaid programs, including their compliance with federal health and safety standards.

I. BACKGROUND

Nursing facilities participating in Medicare and Medicaid must meet a number of federal requirements. These include rules to ensure quality of care, define appropriate nursing and nutrition services, and guarantee residents' freedom from abuse, neglect, and exploitation. To assess whether nursing homes are meeting federal requirements, CMS relies on state agencies that conduct inspections (called surveys) of nursing homes in each of the 50 states, Puerto Rico, and the District of Columbia. CMS and the states can take enforcement action against nursing homes that fail to comply with federal requirements. Such action could lead to a facility being terminated from participating in Medicare or Medicaid.

¹ 42 C.F.R. 483.1 et seq.

² Centers for Medicare & Medicaid Services, *Nursing Home Enforcement* (www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationEnforcement/Nursing-Home-Enforcement.html).

 $^{^3}$ *Id*.

II. CONCERNS ABOUT QUALITY OF CARE AT NURSING HOMES

The Department of Health and Human Services (HHS) Office of Inspector General (OIG) has identified substandard care in nursing homes as a top management challenge for HHS.⁴ According to OIG, because of substandard care, "an estimated 22 percent of Medicare beneficiaries experienced adverse events during their [skilled nursing facility] stays." In particular, OIG has raised numerous concerns about "nursing home residents being at risk of abuse and neglect."

Concerns have also been raised about CMS's commitment to implementing and enforcing regulations to ensure quality of care. In October 2016, CMS issued regulations to strengthen the minimum health and safety standards that nursing homes must meet to participate in Medicare and Medicaid.⁷ The regulations included provisions to improve planning for resident care, staff training, and protections against abuse, among other issues.⁸ The regulations were designed to be implemented in three phases: Phase 1 by November 28, 2016; Phase 2 by November 28, 2017; and Phase 3 by November 28, 2019.⁹

However, in 2017, CMS imposed a moratorium on enforcement for violations of several of the new regulations.¹⁰ CMS has also proposed a rule that would remove a provision from the

⁴ U.S. Department of Health and Human Services, Office of Inspector General, *Top Management and Performance Challenges Facing HHS*, at 20 (2017) (https://oig.hhs.gov/reports-and-publications/top-challenges/2017/2017-tmc.pdf).

⁵ U.S. Department of Health and Human Services, Office of Inspector General, *Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries* (Feb. 2014) (OEI-06-11-00370).

⁶ See note 4.

⁷ Centers for Medicare & Medicaid Services, *Reform of Requirements for Long-Term Care Facilities*, 81 Fed. Reg. 68688 (Oct. 4, 2016) (final rule).

⁸ *Id*.

⁹ *Id*.

¹⁰ Centers for Medicare & Medicaid Services, *Revision to State Operations Manual (SOM) Appendix PP for Phase 2, F-Tag Revisions, and Related Issues* (June 30, 2017) (https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-36.pdf); Centers for Medicare & Medicaid Services, *Temporary Enforcement Delays for Certain Phase 2 F-Tags and Changes to Nursing Home Compare* (Nov. 24, 2017) (https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-18-04.pdf).

2016 rules that prohibits binding arbitration agreements.¹¹ These and other CMS actions have raised questions among consumer groups about whether CMS has weakened enforcement of existing federal health and safety standards for nursing homes.¹²

III. KEY HEARING ISSUES

Over the past 15 years, OIG and the U.S. Government Accountability Office (GAO) have issued numerous reports identifying vulnerabilities in nursing homes and states' and CMS's oversight. Ongoing issues that may be explored at the hearing include the following:

A. <u>Nursing Homes' Efforts to Ensure Quality of Care</u>

OIG and GAO have identified issues with nursing homes' history of providing safe and high-quality care to residents. For example, a 2014 OIG report found that 22 percent of Medicare beneficiaries in skilled nursing facilities experienced an adverse event, over half of which were "clearly or likely preventable" due to substandard treatment and monitoring. OIG has also identified instances of nursing homes failing to report resident abuse and neglect, and shortcomings in their emergency preparedness and response. GAO has also found evidence that consumer complaints have increased in recent years, "indicating a potential decrease in quality."

B. State Survey Agencies Have Uneven Performance

CMS relies on state survey agencies to ensure that nursing homes meet CMS's requirements for participation, but OIG and GAO have found weaknesses in these state efforts.

¹¹ Centers for Medicare & Medicaid, Medicare and Medicaid Programs, Revision of Requirements for LongTerm Care Facilities: Arbitration Agreements, 82 Fed. Reg. 26649 (June 8, 2017) (proposed rule).

¹² Trump Administration Eases Nursing Home Fines in Victory for Industry, New York Times (Dec. 24, 2017).

¹³ *See* note 5.

¹⁴ U.S. Department of Health and Human Services, Office of Inspector General, *Early Alert: The Centers for Medicare & Medicaid Services Has Inadequate Procedures To Ensure That Incidents of Potential Abuse or Neglect at Skilled Nursing Facilities Are Identified and Reported in Accordance With Applicable Requirements* (Aug. 2017) (A-01-17-00504).

¹⁵ U.S. Department of Health and Human Services, Office of Inspector General, *Gaps Continue To Exist in Nursing Home Emergency Preparedness and Response During Disasters:* 2007-2010 (Apr. 2012) (OEI-06-09-00270).

¹⁶ U.S. Government Accountability Office, *Nursing Home Quality: CMS Should Continue to Improve Data and Oversight* (Oct. 2015) (GAO-16-33).

For instance, some states did not investigate the most serious complaints timely¹⁷ or comply with CMS's standards for investigating complaints.¹⁸ Some other states did not always verify that nursing homes corrected deficiencies that the state identified.¹⁹

C. OIG and GAO: CMS's Oversight of Nursing Homes Remains Inadequate

Although CMS delegates to state survey agencies much of the work of ensuring nursing home compliance, CMS is ultimately responsible for overseeing compliance with its health and safety standards. However, OIG and GAO have found that CMS does not always effectively perform this oversight. For example, OIG found that CMS did not have adequate procedures to ensure that nursing homes report potential abuse or neglect, ²⁰ and the agency "has often failed to require nursing facilities to correct all deficiencies identified during the survey process." ²¹

A particular case that may be discussed at the hearing involves a nursing home in Florida. In the aftermath of Hurricane Irma, 14 residents at a facility died after the nursing home lost power and was unable to maintain its air conditioning system.²² In October 2017, bipartisan Energy and Commerce Committee leaders wrote to the owner of that facility to demand answers about the facility's failure to protect its residents, including why the facility failed to comply with federal standards.²³ Witnesses will likely be queried about the circumstances related to this case including how the facility was inspected prior to the hurricane and whether certain lessons can be applied to ongoing nursing home oversight efforts.

IV. WITNESSES

The following witnesses have been invited to testify:

¹⁷ U.S. Department of Health and Human Services, Office of Inspector General, *A Few States Fell Short in Timely Investigation of the Most Serious Nursing Home Complaints: 2011–2015* (Sept. 2017) (OEI-01-16-00330).

¹⁸ U.S. Government Accountability Office, *Nursing Homes: More Reliable Data and Consistent Guidance Would Improve CMS Oversight of State Complaint Investigations* (Apr. 2011) (GAO-11-280).

¹⁹ See, e.g., U.S. Department of Health and Human Services, Office of Inspector General, North Carolina Did Not Always Verify Correction of Deficiencies Identified During Surveys of Nursing Homes Participating in Medicare and Medicaid (Jan. 2018) (A-04-17-02500).

²⁰ See note 14.

²¹ *See* note 4.

²² 2 More Dead After Florida Nursing Home Lost AC During Hurricane Irma, TIME (Oct. 9, 2017).

²³ Letter from Rep. Greg Walden, Chairman, Rep. Frank Pallone, Jr., Ranking Member, et al. House Committee on Energy and Commerce, to Dr. Jack J. Michael, Owner, Rehabilitation Center at Hollywood Hills, LLC (Oct. 20, 2017).

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