

medicaid and the uninsured

January 2013

Implementation of Affordable Care Act Provisions To Improve Nursing Home Transparency, Care Quality, and Abuse Prevention

Executive Summary

The Affordable Care Act (ACA) is the first comprehensive legislation since the Nursing Home Reform Act, part of the Omnibus Budget Reconciliation Act of 1987 (OBRA '87), to expand quality of care-related requirements for nursing homes that participate in Medicare and Medicaid and improve federal and state oversight and enforcement. Despite the 1987 reforms, beginning in 1997, the Government Accountability Office issued more than 20 reports documenting serious quality of care problems in nursing homes and inadequate enforcement of federal regulations to protect residents' health, safety, and welfare. To help address these quality problems, the ACA incorporates the Nursing Home Transparency and Improvement Act of 2009, introduced because complex ownership, management, and financing structures were inhibiting regulators' ability to hold providers accountable for compliance with federal requirements. The ACA also incorporates the Elder Justice Act and the Patient Safety and Abuse Prevention Act, which include provisions to protect long-term care recipients from abuse and other crimes.

This issue paper describes the new ACA requirements, explains the background for their inclusion in the law, and outlines the Centers for Medicare & Medicaid Services' (CMS's) progress in implementing them to date. The new provisions include the following:

Improving Nursing Home Transparency and Accountability:

- Nursing homes must disclose detailed information about individuals and entities that have a direct or indirect ownership interest in or managing control of their operations, in addition to other parties that provide governance, management, administration, operations, finances, and clinical services.
- CMS must establish a national system to collect and report payroll data on direct care staffing levels, including nursing hours, turnover, and retention rates.
- CMS must redesign its Medicare cost reports, and nursing homes must report expenditures by functional category, including direct care, indirect care, capital assets, and administrative services.
- CMS must add new information to its *Nursing Home Compare* website (www.medicare.gov), including staffing information, health inspections, penalties, and consumer complaints.
- CMS must develop a standardized complaint form and a complaint resolution process that assures that residents and their representatives are not retaliated against for filing complaints.

- Nursing homes must establish and operate compliance and ethics programs to prevent and detect criminal, civil, and administrative violations, and CMS must conduct an independent monitor demonstration program to test oversight of nursing home chains.

Targeting Enforcement:

- CMS must revise civil monetary penalty (CMP) requirements, including providing for escrowing CMPs when nursing homes appeal and allowing federal CMPs to be allocated to programs to benefit residents.
- CMS must establish requirements for 60-day prior written notification of impending nursing home closures and appropriate protection and relocation of residents.
- CMS must establish and fund national demonstration projects on culture change and the use of information technology to improve resident care.
- Nurse aides must be trained in dementia care and resident abuse prevention.

Prevention of Abuse and Other Crimes Against Nursing Home Residents:

- CMS must support development of state programs to conduct national criminal background checks on applicants for jobs with direct access to nursing home residents and other recipients of long-term care services.
- Nursing homes, other long-term care facilities that receive federal funds, and their employees must report suspected crimes against residents to law enforcement.

Since the enactment of the new nursing home reforms in the ACA, CMS has made significant progress in implementing many of the requirements. CMS has developed new Medicare cost reporting forms, improved collection of data on owners and managers, added new information on complaints and penalties to *Nursing Home Compare* and provided links to health inspection reports and a searchable database of owners and managers, and developed a standardized complaint form, and it is providing technical assistance on quality assurance and improvement programs for nursing homes. Major provisions still awaiting implementation include finalizing regulations on disclosure of ownership and financial relationships, completing the system for public reporting of nurse staffing information, publicly reporting facility expenditures, and issuing regulations for compliance and ethics programs.

With full implementation of the transparency provisions in the ACA, policymakers and consumers, as well as government and other payers of nursing home services, can better evaluate, not only the quality of care provided by individual facilities but also the costs of care.

Introduction

The Affordable Care Act (ACA) is the first comprehensive legislation since the Nursing Home Reform Act, part of the Omnibus Budget Reconciliation Act of 1987 (OBRA '87), to expand quality of care-related requirements for nursing homes that participate in Medicare and Medicaid and improve federal and state oversight and enforcement. Despite the 1987 reform law, beginning in 1997, the Government Accountability Office (GAO) issued more than 20 reports documenting serious quality of care problems in nursing homes and inadequate enforcement of federal regulations to protect residents' health, safety and welfare. To help address continuing quality of care and enforcement problems, the ACA incorporates the Nursing Home Transparency and Improvement Act of 2009, introduced because complex ownership, management, and financing structures were inhibiting regulators' ability to hold providers accountable for compliance with federal requirements. The ACA also incorporates the Elder Justice Act and the Patient Safety and Abuse Prevention Act, which include provisions to protect nursing home residents from abuse and other crimes.

As a result of the new legislation, notable improvements in nursing home transparency and resident care and protection are in place or in development, although other provisions still await full implementation. This issue brief describes certain provisions related to nursing home transparency and program integrity in Title VI of the ACA, explains the background for their inclusion in the law, and outlines CMS's progress in implementing them to date. The paper primarily focuses on the ACA provisions that directly affect or expand on requirements that nursing homes must meet to participate in Medicare and Medicaid, including Nursing Home Transparency and Program Improvement (Subtitle B), as well as two other provisions in Title VI -- a Nationwide Program for Background Checks on Direct Patient Access Employees (Subtitle C), and the Elder Justice Act (Subtitle H) -- which were designed to prevent crimes against nursing home residents and other long-term care beneficiaries.

BACKGROUND

In 2010, 1.4 million people lived in approximately 16,000 nursing homes, for which expenditures totaled \$143 billion. Medicare, a federal health insurance program for individuals age 65 and older and younger persons with significant disabilities, paid 22 percent of total nursing home costs; 41 percent was paid by Medicaid, a state-federal health insurance program for low-income individuals and their families and individuals with disabilities, or other government programs. The remaining 37 percent was covered by individuals paying out-of-pocket or with private insurance.¹ Nursing homes that participate in the Medicare and Medicaid programs agree to comply with federal health and safety standards; provide a high quality of care and life for each resident; and comply with residents' rights set out in OBRA '87. In addition, nursing homes are required to meet state licensing requirements that may be comparable to or more stringent than federal regulations.

The federal Centers for Medicare & Medicaid Services (CMS) contracts with states to conduct annual unannounced inspections ("surveys") of Medicare and Medicaid-certified nursing homes

to determine their compliance with federal regulations. If “deficiencies” are cited, nursing homes may be required to submit corrective action plans and sanctions may be imposed, including: suspending reimbursement for new Medicare or Medicaid admissions pending correction of deficiencies; collecting civil monetary penalties (CMPs); or placing a temporary manager in the facility until compliance is achieved. Nursing homes can be terminated from participating in Medicare and Medicaid for serious and/or repeat deficiencies.

Between 1997 and 2010, the GAO issued more than 20 reports that found substandard care in many nursing homes; understatement of serious deficiencies by state nursing home surveyors; sanctions for harming residents that were not enforced; facilities that cycled in and out of compliance; and inconsistent and ineffective federal oversight.² During the same period, the Office of Inspector General (OIG) in the federal Department of Health and Human Services (HHS) also issued reports critical of nursing home compliance and state and federal enforcement.³ These studies demonstrated the need for improving the survey process and federal oversight of nursing homes, culminating in the new ACA provisions described below.

PART I. IMPROVING NURSING HOME TRANSPARENCY AND ACCOUNTABILITY

Because complex ownership, management, and financing structures were inhibiting regulators’ ability to hold providers accountable for compliance with federal nursing home requirements, the ACA incorporates the Nursing Home Transparency and Improvement Act of 2009. A number of provisions in the new law are designed to improve nursing home transparency and accountability by strengthening ownership and financial relationship disclosure; mandating accurate reporting of information about nursing staffing; requiring more detailed cost reporting; expanding the publicly available information on the *Nursing Home Compare* website; developing a standardized complaint form and complaint resolution guidance for states; and strengthening compliance and ethics and quality assurance programs.

Disclosure of Ownership and Financial Relationships

Seventy percent of nursing homes are operated on a for-profit basis, and more than half are controlled by chains comprising two or more facilities. Over the past two decades, nursing home providers have developed increasingly complex operational structures. (For example, the HHS OIG found 17 limited liability companies involved in the ownership of one nursing home it investigated for substandard care.)⁴ Strategies employed include diversifying into other long-term care services (e.g., home health care and hospice); creating multiple limited liability companies with operational roles; separating corporate assets from entities that manage the facilities; and selling the physical properties to Real Estate Investment Trusts. These strategies allow owners to protect themselves from being held accountable or liable for serious deficiencies in individual nursing homes while increasing profits.⁵

The impact of nursing home ownership structures on care quality was described in a 2007 *New York Times* investigation that focused on more than 1,200 nursing homes purchased by private investment groups. The *Times* reported that, on average, resident outcomes worsened after

private equity groups bought the nursing homes and that their outcomes were worse relative to other nursing homes.⁶ The GAO has reported that private equity-owned nursing homes have an average of eight owners per home. When investors purchase nursing homes, they may cut staff and other direct care costs to maintain profitability.⁷ These ownership structures, which were the subject of three Congressional hearings in 2007 and 2008,⁸ make it difficult for regulators to ensure that the entities that ultimately control nursing homes are held accountable for the quality of care they provide.

In 2003, CMS began collecting nursing home ownership information in the Medicare Provider Enrollment, Chain and Ownership System, or PECOS. The GAO described the self-reported data in PECOS as incomplete and confusing, making it difficult for regulatory agencies and laypersons to determine how entities are related and track systemic problems in nursing homes with common owners or managers.⁹ Moreover, PECOS did not collect information on all entities that may play a direct role in a nursing home's operations. Because of evidence that complex business structures have a negative impact on the care of residents and accountability to taxpayers, the ACA sets out detailed new ownership and operational information that nursing homes must report to CMS and requires it to be available to the public.

ACA Requirements: Section 6101 of the ACA is the keystone of the new nursing home transparency law. It requires nursing homes to disclose detailed information about their organizational structures and entities and individuals with at least a 5 % ownership interest in the real estate, corporation, or limited liability company. In addition, nursing homes must report individuals and entities that provide other aspects of their governance, management, administration, operations, finances, operational policies and procedures, and clinical services, including consultants. The list includes officers, directors, partners, and trustees; the managing employee of the facility and other individuals who directly or indirectly manage, advise or supervise its practices, finances and operations; and those who lease or sublease property to the facility. Federal and state regulators and state long-term care ombudsman programs were authorized to request the information from nursing homes immediately after the law's enactment, and CMS is required to have procedures to make ownership information available to the public by March 2013.

Implementation: CMS published proposed ownership disclosure regulations for public comment in May 2011¹⁰ that closely followed the detailed ACA language. However, in August 2011,¹¹ CMS announced that it was deferring publication of a final rule until 2012 in order to "respond properly" to the comments it had received on the proposed regulations. Final regulations, due by March 2012 under the law, have not been published, although CMS has significantly increased the information it requires nursing homes to report and recently included information about owners, directors, partnerships, and managers in a searchable database linked to *Nursing Home Compare*.

In the proposed rules, CMS requested public comments on how to reduce the reporting burden on providers. CMS said it might be difficult for some nursing homes to identify all individuals and entities the law lists as "additional disclosable parties" without explicit guidance. Advocates

became concerned that CMS was reluctant to provide detailed guidance and might not require nursing homes to report persons or entities that the law intended to disclose.¹² While the proposed rule would require any change in a nursing home's disclosable information to be reported within 30 days, CMS requested public comments on whether or not the information should be reported only during each facility's currently mandated five-year Medicare revalidation (re-enrollment) process. The enrollment regulations require changes in ownership or control to be reported within 30 days but other changes to be reported within 90 days.¹³

Although CMS has not moved forward with final regulations implementing Section 6101, in July 2011, it substantially increased the amount of information nursing homes and other institutional providers must submit through PECOS to enroll or remain in Medicare and Medicaid.¹⁴ The new reporting format does not cover all elements required by the ACA. However, it is consistent with ACA provisions that require nursing homes to disclose information about individuals and entities with at least a 5% direct or indirect ownership interest or operational or managing control, including holders of mortgages, deeds of trust and other security interests; partnerships; officers and directors; organizational structures, showing relationships among the owners and other reported entities; and contractual services. If a nursing home is part of a chain, the chain's home office administrator must also be reported.

The new information is recorded in PECOS when providers apply for Medicare or Medicaid certification; when there is a change in the information; and during their five-year revalidation process. Fulfilling program integrity (fraud prevention) requirements in Section 6401 of the ACA, CMS is requiring all Medicare and Medicaid providers to revalidate their enrollment by March 2015.¹⁵

Accurate Information about Nurse Staffing

A 2001 Congressionally-authorized HHS study concluded that 97 percent of nursing homes did not provide a sufficient number of hours of nursing care a day. The study found that a minimum of 4.1 to 4.85 hours of combined registered nurse (RN), licensed practical nurse (LPN), and nursing assistant care are needed on a daily basis to prevent harm to residents in critical care areas, such as prevention of pressure sores and weight loss.¹⁶ Although many consumers and healthcare professionals support legislating minimum staff-to-resident ratios to ensure adequate care, anticipated Medicaid cost increases have been a deterrent to passing such legislation.

Because nurse staffing is an important quality indicator, CMS's *Nursing Home Compare* website presents nurse staffing hours, by type, for each nursing home. To receive the highest rating on the Nursing Home Five-Star Quality Rating System, facilities must meet the minimum nurse staffing level (4.1 hours) recommended by the 2001 HHS study.

Staffing data are self-reported by nursing homes to CMS during the two-week period prior to their annual surveys. The 2001 HHS study found that nursing home staffing data based on these reports were not reliable; and it recommended establishing a system to collect staffing data

from auditable and verifiable sources such as payroll records, temporary agency contracts, and cost reports. Researchers maintained that this data collection system would improve the accuracy of *Nursing Home Compare* staffing data and allow CMS to develop quality measures based on staff turnover and retention rates. CMS has been developing a payroll reporting system since 2001.

ACA Requirements: Section 6106 of the ACA imposed a March 2012 deadline for CMS to implement its decade-long effort to develop a program to collect data on nurses and other direct care staff from payroll records, agency contracts, and cost reports. When the system is completed, nursing homes will use a uniform format developed by CMS to report total number of residents, resident case mix, turnover and retention rates, and daily hours of care provided by each direct care employee category for both regular and contract employees.

Implementation: Citing workload and costs, in December 2011, CMS said the ACA requirement would not be fulfilled for two or three more years.¹⁷ CMS is field-testing a prototype of a system to collect the data,¹⁸ but it has no new projections for when reporting will be implemented for all Medicare and Medicaid nursing homes. As a result, consumers, regulators, policymakers, and government and private entities that pay for nursing home care depend on unreliable data to assess the most critical aspect of a nursing home's services. Monitoring staffing adequacy has become increasingly important because of nursing home industry statements that facilities will cut staff if Medicare or Medicaid reimbursement decreases. Following CMS's correction of Medicare overpayments to nursing homes in FY 2012,¹⁹ for example, a nursing home trade association warned that the government's action could result in nursing homes eliminating jobs.²⁰

Financial Disclosure

Congressional hearings on nursing home transparency and accountability in 2007 and 2008 focused on concerns that owners were taking too much income from nursing homes as profits while failing to meet Medicare and Medicaid quality of care requirements.²¹ Medicare profit margins for skilled nursing facilities (SNFs) have increased steadily since 2005. In 2010, the average for-profit margin was 20.7 percent, the 10th consecutive year above 10 percent. This was more than twice the average margin of non-profit facilities,²² which tend to have higher staffing levels and fewer quality problems.²³ The nursing home industry maintains that high Medicare margins merely balance out low Medicaid reimbursement rates set by states.²⁴ However, the total margin for SNFs from all payment sources was 3.6 percent, according to the Medicare Payment Advisory Commission (MedPAC). MedPAC maintains that Medicare reimbursement is adequate based on information that some nursing homes demonstrate that it is possible to have below-average costs, above-average quality, and adequate Medicare margins.²⁵

Medicare does not require nursing homes to allot a specific proportion of their Medicare revenue to resident care, even though Medicare rates are based on forecasted expenditures for the type of care residents are expected to receive. While nursing homes were required to

submit annual Medicare cost reports prior to the ACA, they were not required to clearly separate direct and indirect care costs from capital, administration, and profits, and there was no federal mechanism to make the information readily available to the public.²⁶

ACA Requirements: Responding to these concerns, the ACA (§ 6104) requires providers to categorize expenditures from all payment sources on their cost reports and indicate if the expenses are for: (1) direct care, including nursing, therapy, or medical services; (2) indirect care, including housekeeping and dietary services; (3) capital expenses, such as building and land costs; and (4) administrative services. Under the ACA, CMS was required to redesign Medicare cost reports to capture this information by March 2011; categorize the expenditures by September 2012; and develop procedures to make the information readily available when requested.

Implementation: CMS has begun using a new Medicare cost report form (SNF 2540-10) that reports expenditures for the four cost centers mentioned above, as required by the ACA. The form also collects data on direct care expenditures by the following categories: full-time and part-time workers and contract staff; paid wages and benefits by category; hours worked; and average expenditures per hour for each nursing and therapy category. CMS expects to have the capacity to make expense data uniformly available to the public in 2013.

Improvements to *Nursing Home Compare* Website

The *Nursing Home Compare* website²⁷ was launched in 1998 to help consumers compare nursing homes based on measures such as number of deficiencies on their health inspections; nurse staffing levels; and quality measures based on resident assessment data for the number of residents with pressure sores, physical restraints, pain, loss of mobility, and other conditions associated with the quality of care. In 2008, CMS added the Nursing Home Five-Star Quality Rating System, which provides individual and composite ratings for nursing homes based on their health inspections, nurse staffing hours, and selected quality measures.

Nursing Home Compare reports the categories of deficiencies surveyors cite during surveys; however, for years most consumers had to request copies of health inspections (CMS Form 2567) from the state survey agency or the facility itself if they wanted a description of the conditions surveyors found. (Some states posted survey reports online.) In addition, *Nursing Home Compare* displayed the number of deficiencies received by facilities but not what kind of penalties, if any, they received. No information was available about the number or substance of complaints filed with state survey agencies, although complaints may provide more timely alerts about poor care and other problems reported by residents, families, and staff.²⁸

ACA Requirements: Section 6103 of the ACA requires CMS to review, update, and improve the *Nursing Home Compare* website with timely, accessible information that is easily understood by consumers. The additions required by the ACA include:

- Staffing data from payroll records and other auditable sources from the system required by Section 6106 showing daily hours of direct care and staff turnover and tenure.
- A standardized voluntary complaint form (§ 6105) and consumer guidance for filing complaints with state survey agencies and state long-term care ombudsman programs.
- A summary of the number, type, severity, and outcome of substantiated complaints and information on the number and types of crimes committed by facilities or their employees, contractors, and/or agents and CMPs levied against them.
- Links to state websites with completed health inspection and complaint investigation reports (CMS Form 2567), instructions on how to interpret the report findings, and facility corrective action plans.

To increase the timeliness of information, states are required to submit survey results to CMS at least quarterly.

Section 6103 provides for CMS to conduct a Special Focus Facility (SFF) program with enhanced surveys in facilities that have “substantially failed” to comply with Medicare and Medicaid care quality requirements. CMS has conducted an SFF program in several facilities in every state since 1998 under its regulatory authority. SFF facilities are designated with a warning icon on *Nursing Home Compare*.

Implementation: CMS began adding ACA-required information to *Nursing Home Compare* in April 2011. In July 2012, CMS introduced a redesigned website that includes new search functions and new facility-based performance indicators. The additions also include a standardized complaint form; guidance on filing complaints; links to state consumer websites; and the number of substantiated complaints, CMPs, and denials of payment for new admissions for each facility.

Several changes were made to the quality measures, including updating the data to the latest version of CMS’s nursing home resident assessment instrument, the Minimum Data Set (MDS).²⁹ A new measure showing the number of residents who receive antipsychotic drugs was added as part of a CMS initiative to reduce the widespread misuse of antipsychotics. The *Nursing Home Compare* website now allows users to click a link to create bar graphs that compare nursing homes’ performance on quality measures with that of other homes and with state and national averages.

CMS has not pressed states to comply with the ACA’s requirement to maintain consumer websites that post state health inspection and complaint investigation reports (2567s) and facilities’ formal plans to correct deficiencies. Instead, in July 2012, CMS began posting 2567s for every Medicare and Medicaid certified nursing home on *Nursing Home Compare*. CMS redacts some information (such as medication names and medical conditions) from the reports because it says the information could help identify individual residents and compromise their privacy. This redaction results in a loss of information that could identify specific care problems, such as misuse of antipsychotics or failure to prevent pressure sores. (Most states that post 2567s do not redact such information.) As they become available, three years of full reports on

annual surveys and complaint investigations will be posted for every nursing home. CMS is also developing its own capacity to post plans of correction. Meanwhile, only about half of states have the required consumer websites.

Since the ACA requirement for staffing information to be collected from payroll records (Section 6106) has not been implemented, *Nursing Home Compare* and the Five-Star Rating System still use unaudited, self-reported data. Professional physical therapist hours were added to *Nursing Home Compare* (although not included in the five-star ratings) in July 2012, but these data are also self-reported by facilities. Until the new system is in place, *Nursing Home Compare* will be unable to provide reliable information about the adequacy of facilities' direct care staffing, including turnover and retention rates. An additional ACA provision that requires *Nursing Home Compare* to report adjudicated crimes by facilities and employees has also not been implemented.

As noted previously, CMS has also not yet finalized regulations on the detailed disclosure of individuals and entities involved in nursing homes' ownership, operations, services, governance, and financing (Section 6101). Nevertheless, in October 2012, *Nursing Home Compare* began reporting facilities' owners and managers based on data newly collected through PECOS. Resources available on the site include a searchable database of individuals and entities with a 5% or more ownership interest, entities with operational or managerial control, directors and officers, general partnerships, and managing employees. Users can identify and compare the quality of all facilities in which these individuals or companies have a business interest.³⁰ Data and reporting mechanisms should improve as nursing homes update their PECOS reports to meet new reporting requirements implemented in July 2011; but final ACA regulations are needed to clarify reporting timeframes and a full list of disclosable entities and individuals.

The public's ability to assess and compare the quality of nursing homes has improved significantly since CMS began to add ACA-required data to *Nursing Home Compare* in 2011 and improved the format in 2012. CMS officials say they are continuing to improve both the information and the format in which it is presented. However, some gaps in available information remain because ownership disclosure reporting requirements have not been fully resolved; staffing data collection from payroll records has not been implemented to improve the accuracy of information about the quality of staffing in facilities; crimes committed by nursing homes and their employees are not reported; and about half the states appear to be out of compliance with the ACA mandate to maintain consumer-oriented websites.

Standardized Complaint Form and Complaint Resolution Process

State survey agencies received more than 53,000 complaints about nursing homes in 2009, according to a 2011 GAO study. Fifty-five percent of the complaints cited immediate jeopardy or serious harm to residents, and almost half of the complaints originated from family members (10 percent were filed by residents). About three-quarters of complaints were made via telephone. Only 19 percent of complaints cited in the GAO study resulted in a deficiency determination, possibly because of delays in investigations.³¹

Despite the large number of complaints, many residents and families do not report problems because they fear retaliation. Consumer advocates sought stronger protections for family members who complain about poor care after reports increased about family members who were denied visitation or restricted in their access to their loved one after they complained to staff, an ombudsman, or state official about the quality of care. Consumer groups also advocated for standard requirements for more timely and thorough complaint investigations and follow up.

ACA Requirements: The ACA (§ 6105) requires a standardized complaint form to be made available to residents and their representatives to facilitate their ability to compose and file complaints with appropriate supporting information. The ACA specifies that its use is voluntary and that it must be accessible on *Nursing Home Compare*. States must establish a complaint resolution process that assures that a resident's legal representative or other responsible party is not denied access to the resident or retaliated against in other ways for filing a complaint. The complaint process must include: (1) accurate tracking of complaints, including notifying the complainant that the form has been received by the appropriate agency; (2) procedures to determine complaint severity; and (3) deadlines for responding to the complaint and notifying the complainant of the outcome.

Implementation: As noted above, CMS developed a standardized complaint form and made it available to states and consumers on its *Nursing Home Compare* website in 2011. The website provides consumers with information on how to properly file complaints and also how to contact state survey and certification agencies and the state long-term care ombudsman program.

In March 2011, in anticipation of publication of the GAO report on complaints, CMS formed a Complaint Consistency Workgroup to respond to issues raised in the report. To date, no regulations or formal guidance on complaint procedures and the protection of complainants have been issued.

Compliance and Ethics, Quality Assurance, and Improvement Programs

Over the years, the federal government has employed three internal mechanisms for nursing homes to improve quality and compliance. First, OBRA '87 requires nursing homes to have quality assurance committees and a quality assurance plan, although state surveyors rarely give deficiencies for failure to comply. Second, the Department of Justice established Corporate Integrity Agreements (CIAs) as part of the settlement in cases against providers for fraud and/or failure to comply with federal quality requirements. CIAs require nursing homes to employ an independent monitor and have a quality assessment and assurance (QAA) committee to oversee quality improvement efforts. (An HHS OIG evaluation found that nursing home QAA plans did not appear to address the root causes of care quality problems.³²) Third, the HHS OIG published guidelines for voluntary compliance and ethics programs in 2000 and 2008 to help facilities detect and correct compliance problems that could result in civil or criminal actions. In

2008, the HHS OIG recommended that Congress establish demonstration programs to explore different approaches for compliance programs.³³

ACA Requirements: The ACA authorizes two new, mandatory internal compliance programs and a demonstration project to improve oversight of nursing home chains. First, nursing homes are required to establish compliance and ethics programs to prevent and detect criminal, civil, and administrative violations and promote quality by March 23, 2013 (§ 6102). CMS and the OIG were required to jointly develop regulations that were to be published by March 2012. Second, CMS was to provide nursing homes and chains with (1) Quality Assurance and Program Improvement (QAPI) standards and (2) technical assistance in developing best practices to meet the standards by December 2011 (§ 6102). Within one year after CMS releases the QAPI regulations, nursing homes must submit a plan to implement the standards.

Third, in consultation with the HHS OIG, CMS is to conduct a demonstration project to develop an independent monitoring program to oversee interstate and large intrastate chains of nursing homes (§ 6112). Chains may apply for projects, and states may target facilities, for example facilities with severe and repeated deficiencies.

Implementation: CMS solicited recommendations on how to implement compliance and ethics programs in September 2010; but in February 2011, it announced that it would withhold publication of proposed regulations until an unspecified time in the future.³⁴ Although CMS has not issued final regulations, the HHS OIG stated in its *2012 Work Plan* that it will monitor facilities' implementation of compliance plans in their daily operations and whether they comply with OIG's 2000 and 2008 guidance for voluntary compliance and ethics programs.³⁵ The OIG also said it will assess whether CMS has incorporated compliance and ethics plans into its requirements to participate in Medicare and Medicaid and whether CMS is overseeing providers' implementation of compliance plans.³⁶

To date, CMS has not issued plans to conduct the independent monitor demonstration project; and QAPI is the only one of the three ACA-required programs described in this section that CMS is currently implementing to ensure that facilities continuously identify and correct quality deficiencies and sustain improvement. In 2011, CMS launched a QAPI demonstration project in a sample of nursing homes in four states to test implementation strategies and the effectiveness of CMS-provided resources and technical assistance. In 2012, it surveyed an additional sample of nursing homes about barriers to implementing effective QAPI programs. In December 2012, CMS released a preview of its guide for providers ("QAPI at a Glance") with resources to help nursing homes implement their QAPI programs.³⁷ CMS told state surveyors in June 2012 that it was working on QAPI program guidance required by the ACA, but to date, regulations have not been published.³⁸

PART II. TARGETING ENFORCEMENT

The ACA also includes mechanisms to improve nursing home quality through new CMP provisions, improved notification requirements when nursing homes close, demonstration

programs on culture change and information technology, and required dementia and abuse prevention training for staff.

Civil Monetary Penalties

More than half of federal remedies for nursing home violations are CMPs. Daily CMPs can range from \$50 to \$10,000 while a facility remains out of compliance, but CMPs are typically \$350 to \$500 per day.³⁹ Facilities can also incur “per instance” CMPs ranging from \$1,000 to \$10,000.

Nursing homes have two ways to challenge CMPs. The first mechanism is an informal dispute resolution (IDR) with the state survey agency. The IDR process has substantially reduced the number of deficiencies cited in some states. Nationally in 2007, 20 percent of disputed deficiencies were deleted and seven percent downgraded in scope and severity during the IDR process; in four states, at least 40 percent of deficiencies were deleted through IDR challenges. Surveyors in some states told the GAO that problems related to IDRs--such as frequent hearings, downgrading or deleting of deficiencies, and outcomes that favored providers over residents--may have contributed to underciting of deficiencies. Several survey agency directors said frequent IDR hearings contributed to understatement of deficiencies and even hesitation to cite deficiencies that might be disputed.⁴⁰

The other option for nursing homes is a formal appeal to an administrative law judge (ALJ) or the HHS Departmental Appeals Board. CMPs take twice as long to be collected when deficiencies are appealed.⁴¹ Delays in the appeal process can reduce deficiencies’ deterrent effect, even though ALJs uphold deficiencies 93 percent of the time.⁴² In September 2010, the GAO recommended developing a process for states to collect and hold CMPs until the appeal determination.⁴³

States and the federal government split CMPs collected for Medicaid deficiencies, but Medicare CMPs went to the U.S. Treasury as general revenue prior to the ACA. In 2005, states reported having \$60 million in CMP accounts. Most funds were unused or used for survey activities, although some states funded providers, advocacy groups, and state ombudsman programs to improve resident care.⁴⁴

ACA Requirements: The ACA authorizes CMS to require providers to place CMPs in escrow pending the outcome of a formal appeal (§ 6111). If the facility prevails, the funds are returned with interest. Before a CMP is placed in escrow, however, the nursing home can request that an independent informal dispute resolution (independent IDR) be conducted by an entity separate from the state survey agency. The funds must be placed in an escrow account within 90 days of the imposition of the penalty or the completion of the independent IDR, whichever is first. Facilities that waive their right to a hearing and promptly report and correct deficiencies may receive a 50 percent reduction in a CMP, unless the violation caused immediate jeopardy to residents, was part of a pattern or widespread harm, resulted in a resident’s death, or was the cause of a previous CMP.

Under the ACA, CMS is authorized to use “some portion” of federal CMPs for activities to benefit residents. Allowable uses include assisting residents in the event of nursing home closure; relocating residents to home and community-based settings or another facility; and supporting resident and family councils and consumer involvement to assure quality care. CMPs can also be used for facility improvement initiatives approved by CMS, including joint training of staff and surveyors; technical assistance implementing quality assurance programs; and the appointment of temporary managers in facilities with chronically substandard care.

Implementation: CMS issued final civil monetary penalty regulations on March 18, 2011 that became effective January 1, 2012.⁴⁵ The independent informal dispute resolution rules were supplemented by Interim Advance Guidelines disseminated to state survey agencies on December 2, 2011.⁴⁶ Independent IDRs may be conducted by a state department that is separate from the agency that conducts health inspections, or by an independent entity identified by the state with no conflict of interest and an understanding of Medicare and Medicaid requirements.

The independent IDR must generate a written record and the state survey agency must make a determination within 10 business days. CMS took several steps to keep the independent IDR process from obstructing enforcement with unsupported provider requests for reviews of deficiency findings. The regulations:

- prohibit facilities from requesting an independent IDR if they had an IDR after a CMP was imposed;
- allow nursing homes to challenge the facts of a deficiency but not other aspects of the survey process;
- make independent IDR recommendations advisory, not binding on, the state survey agency and not subject to appeal;
- give CMS ultimate authority to determine survey findings and imposition of CMPs; and
- allow “daily” CMPs to continue to accrue during the independent IDR process.

Consumer advocates have advocated for years for residents and their representatives to be allowed to challenge surveys that fail to cite problems or impose appropriate sanctions. The ACA regulations provide the first opportunity in federal law for consumers to participate in an appeal process. The state long-term care ombudsman and “involved residents” (residents or their representatives who filed a complaint related to a deficiency) must be notified of their right to submit written comments in the independent IDR if a deficiency is appealed. The state is not required to notify complainants or the ombudsman of the outcome of the independent IDR.

The independent IDR process may present an enforcement obstacle if it results in numerous hearings or if surveyors do not cite deficiencies or downgrade them in anticipation of a reversal. The regulations prohibit conflicts of interest but permit individuals associated with nursing homes (e.g., an employee, owner, or financial entity) to be members of the independent IDR

entity as long as they have not been associated with the facility under review in the previous year.

CMS has used its discretion under the ACA to allocate 90 percent of federal CMPs to support activities that benefit residents; this action provides substantial new resources for initiatives to improve residents' care. CMPs cannot be used to cover the cost of medical or other services or activities that have another federal funding source. A variety of entities, including nonprofit organizations, can apply for grants to use CMP funds, and all applicants must involve resident and family councils and direct care staff in developing and implementing CMS-approved projects.⁴⁷

Notification When Nursing Homes Close

The closing of a nursing home, whether done voluntarily by an owner or under the threat of termination of Medicare and Medicaid payments, can be traumatic for residents. Even when a facility is involuntarily shut down after years of substandard care, it may be difficult to find a suitable alternative in the resident's community. Usually, residents are transferred to another nursing home, even if they would prefer to be placed in a private home or in another community-based setting. Relocating residents is substantially more difficult when owners give insufficient notice of their plans to close. In the past, involuntary closures were often accelerated as a result of CMS's inability under pre-ACA requirements to continue Medicaid payments until all residents were placed in suitable residences.

ACA Requirements: The ACA reduces the problem of abrupt, chaotic shutdowns by requiring nursing home administrators to give residents, their representatives, the state survey agency, and the state long-term care ombudsman at least 60 days' written notice that a facility will close voluntarily (§ 6113). In cases of involuntary closure when Medicare and Medicaid agreements are terminated, CMS determines the appropriate date of closure. Administrators who fail to comply can be fined up to \$100,000 and excluded from working in any federal health care program. A facility that elects to close cannot admit new residents.

The notification must include a plan for adequate relocation of residents, including assurances that residents will be transferred to the most appropriate setting in terms of quality, services, and location. Transfer plans must also take into account residents' needs, choice, and best interests. Before the facility closes, the state must ensure that all residents have been successfully relocated; and CMS may continue payments until relocation is completed.

Implementation: This ACA provision became effective in March 2011. CMS implemented it with interim final regulations for comment in February 2011,⁴⁸ and guidance was issued to state survey agencies on April 1, 2011.⁴⁹ CMS says it anticipates that the final rule will be published with minor editorial changes.

Advocates have expressed several concerns about CMS's proposed implementation. First, the maximum penalty on an administrator for noncompliance was reduced from the \$100,000

allowed by the law to \$500 for the first offense and up to \$3,000 for a third violation. Second, residents do not have appeal rights in the case of inappropriate or unsatisfactory transfers. Moreover, the notification requirements are not applied when an owner converts a nursing home or a unit of a nursing home to provide services for individuals who receive a different type of care, such as Medicare-only rehabilitation services. Medicaid beneficiaries and private pay residents in facilities that are changing their business plans to enroll more lucrative skilled Medicare patients may be evicted, as they were before the ACA, without adequate notice or relocation assistance.

Demonstration Programs on Culture Change and Information Technology

OBRA '87's language requiring high quality of care and life for *each* resident in a home-like environment provided a regulatory underpinning for the "culture change" movement that has developed in the two decades following OBRA's implementation. CMS has supported the movement with information, technical assistance to facilities, training of surveyors, and review of regulations to remove unnecessary barriers to creating more home-like environments. Although some nursing homes have the necessary information technology infrastructure, overall the nation's 15,800 nursing homes have lagged behind other healthcare settings in the use of information technology to improve clinical care and personalize care delivery.

ACA Requirements: The law (§ 6114) authorizes two national demonstration projects to improve resident care through culture change and information technology. One grant would be awarded to facilities that are involved in culture change to develop best practice resources, and the other grant opportunity would develop best practices in the use of IT to improve resident care.

Implementation: To date, no funds have been allocated to conduct the projects.

Dementia and Abuse Prevention Training

Nationally, more than half of all nursing home residents have Alzheimer's disease or another form of dementia. Nursing assistants provide 80 to 90 percent of hands-on care, but they often have minimal job preparation to provide care to persons with dementia. Direct care workers with little to no training in dementia care may misinterpret residents' behavior as aggression, rather than as symptoms of their disease or inability to communicate their needs. Heavy workloads may also increase nursing assistants' stress levels and further inhibit their ability to interpret and address behavioral symptoms that are caused by residents' disease or inability to communicate pain, anxiety, fear, and other needs.

OBRA '87 required nursing assistants to have 75 hours of training but did not require dementia care or abuse prevention to be included in the curriculum. Only 13 states and the District of Columbia require nursing assistants to have at least 120 hours of training as recommended by a National Institute of Medicine consensus report.⁵⁰ Many professionals and experts view the

federal training requirement to be inadequate, especially since most nursing assistant training is provided on-the-job.⁵¹

ACA Requirement: The ACA requires nursing assistants to be trained in dementia care and abuse prevention (§ 6121). The law provides for the new requirements to be added into the existing 75 hours of training required by OBRA '87. HHS may also require that such topics be covered in nursing assistants' ongoing training.

Implementation: Implementation of the requirement to train nursing assistants in dementia care and abuse prevention dovetailed with CMS's initiation of a national campaign in April 2012 to address the misuse of antipsychotic drugs to sedate and chemically restrain nursing home residents with dementia. CMS is providing to each Medicare and Medicaid nursing home a six-hour curriculum called "Hand in Hand," which can be used for initial and in-service training of nursing assistants and other staff. The new curriculum requirement is a major step in improving nursing assistant training. However, its effectiveness may be limited if nursing homes include it in the existing 75 hours of training rather than adding on to the basic training program. In addition, the high turnover of nursing assistants creates a continuing challenge to maintain a trained direct care workforce in nursing homes.⁵²

PART III. PREVENTION OF ABUSE AND OTHER CRIMES AGAINST NURSING HOME RESIDENTS

The ACA incorporates provisions from the Elder Justice Act and the Patient Safety and Abuse Prevention Act for prevention and reporting of abuse and other crimes, including expanded provisions for national and state background checks on employees and a federal requirement to report suspected crimes in facilities. Nursing home abuse is believed to be widely underreported, either because residents are unable to complain or because they, their families, and caregivers fear retaliation by providers. Although nursing homes are required to report abuse to state survey agencies, facility administrators may be reluctant to alert police because they fear adverse publicity and/or federal or state sanctions⁵³

National and State Background Checks on Long-Term Care Employees

OBRA '87 prohibits nursing homes from employing persons convicted of crimes against residents. In addition, nursing assistants who are found to neglect or abuse residents or take their property are listed in a state registry and prohibited from working in nursing homes. OBRA '87 does not explicitly require either state or national background checks on employees, and the registry is not required to include staff other than nursing assistants.

While forty-three states required some type of background check on nursing home job applicants in 2011, an HHS OIG review of employee FBI records from a sample of nursing homes found that 44 percent of their employees had a conviction for crimes against property, such as burglary, shoplifting, or writing bad checks. Overall, 92 percent of the sampled facilities had at least one employee with some type of criminal conviction, and nearly half employed five or more workers with at least one conviction.⁵⁴

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, § 307) established pilot programs in seven states to develop model procedures to conduct fingerprint-based state and federal background checks on prospective long-term care employees. The model background check programs disqualified more than 9,500 applicants.⁵⁵

ACA Requirements: Section 6201 expanded the pilot program to make all states and territories eligible to apply for grants to design comprehensive criminal background checks on long-term care employees with direct access to residents or patients. Providers in participating states must search federal and state criminal history records and abuse registries for all states in which a prospective employee resided. The law provides for job applicants to appeal decisions and for a 60-day provisional employment period while background checks are conducted. States must specify crimes that disqualify applicants and also develop procedures to notify employers if active employees are convicted of a crime.

Implementation: The ACA allocated \$160 million for grants to support state criminal background check programs. As of March 2012, CMS had awarded \$38.6 million to 17 states and the District of Columbia. In spite of a 3:1 federal match that allows states to include in-kind contributions in their share, only half the states had applied for grants after seven CMS solicitations for applications, and only 19 had been approved by the end of 2012. The reluctance of states to apply may be related to state fiscal concerns. In December 2012, CMS notified states it would issue an eighth solicitation for applications, which will close January 31, 2013. CMS renewed a previous offer to help states to address implementation issues.⁵⁶

Reporting a Suspicion of a Crime in a Long-Term Care Facility

Nursing homes are required under OBRA '87 to report abuse of residents to the state survey agency, and survey agencies must adhere to strict timelines when processing and investigating complaints. OBRA '87, however, had no federal requirement for nursing home administrators or employees to report suspected crimes to local law enforcement, and individual employees also had no obligation to report crimes to the state.

When crimes are committed in nursing homes, police involvement has been infrequent, and when police are involved, it is often late in the investigatory process, making collection of evidence and prosecution difficult.⁵⁷ Requiring long-term care facilities and their employees to report suspected crimes to law enforcement officials was a key provision in Elder Justice Act to prevent repeat abuse and remove abusers from employment in long term care facilities.

ACA Requirements: The ACA (§ 2046) stipulates that owners, operators, employees, managers, agents, and contractors of long-term care facilities that receive at least \$10,000 in federal funds must report any reasonable suspicion of a crime against a resident to the state survey agency and local law enforcement agencies. Crimes are defined according to applicable local laws. Suspected crimes that result in serious bodily injury must be reported within two hours; other suspected crimes must be reported within 24 hours. Covered individuals who fail to file a report

can be fined up to \$200,000 or up to \$300,000 if their failure to report increases the harm to the victim or another person. Individuals failing to file a report can also be banned from working in a facility that participates in the Medicare or Medicaid programs.

Facilities that retaliate against an employee who reports a crime are subject to a CMP up to \$200,000 and may also be excluded from participating in any federal health care program. Facilities are required to post a notice in a prominent place that describes procedures employees should follow to file a complaint if they are retaliated against.

Implementation: The ACA requirement became effective in March 2011. In January 2012, CMS sent state survey agency directors a fourth memo describing facilities' obligations under the law;⁵⁸ however, regulations have not yet been published. The CMS guidance requires facilities to remind workers once a year of their responsibility to report, which may be too infrequent given high employee turnover rates. Facilities are not required to post reporting requirements or protocols. If employees fail to report within required time frames, they may face stiff financial penalties and be prohibited from working in a nursing home for a two-year period.

CMS guidance does not address potential conflicts between local criminal laws and state nursing home regulations for reporting and response timeframes. Reportable crimes vary according to local laws, and these variations are left to nursing homes and law enforcement to address. No guidance was given on protecting workers from retaliation when they report, even though direct care workers are a vulnerable employee group who may have few resources to fall back on if they lose their jobs. Twenty percent are single parents; 55 percent have a high school education or less; 46 percent live in households that receive public assistance; and 23 percent are foreign-born.⁵⁹ CMS's guidance allows administrators to file reports on an employee's behalf, but the burden is on the employee to ensure that the administrator files a full report.

DISCUSSION

The nursing home transparency and quality improvement requirements in the ACA are the first major legislative reforms since the 1987 Nursing Home Reform Act. Since the transparency and quality improvement provisions were enacted under the authority of the ACA, CMS has made significant progress in implementing many of the new requirements.

CMS has implemented new Medicare cost reporting requirements to collect detailed data on direct care expenditures by category, although it has not yet developed a system to report the data to policymakers and the public. The [Medicare.gov Nursing Home Compare](https://www.medicare.gov/nursinghomecompare) website has been updated with new information on consumer complaints and enforcement actions taken against facilities, including CMPs. Detailed new data from health care inspection reports and complaint investigations are now available on *Nursing Home Compare*, along with updated quality measures and information on nursing homes' use of antipsychotic drugs. CMS also provides a standardized complaint form, which is available on *Nursing Home Compare* and state consumer information websites, along with information on how to file complaints and contact

state survey officials and the state long-term care ombudsman program. In addition, CMS is implementing a quality assurance and performance program to engage nursing homes in self-improvement activities--although implementing regulations for providers are still to be published.

Some other components of the ACA nursing home legislation have not been completely implemented to date.

Requiring nursing homes to report detailed information on ownership, management, and financing structures was the signature requirement of the transparency law. It was strongly supported by policymakers, federal and state prosecutors, and consumer advocates as a strategy for holding diverse entities and individuals accountable for quality of care rendered, the majority of which is paid for with taxpayers' dollars. CMS revised its Medicare enrollment and PECOS reporting form in 2011 to substantially increase the information it collects on owners, managers, investors, and others, and it is in the process of adding a substantial amount of this information to a searchable database on Nursing Home Compare. However, it has not yet published final regulations delineating all parties that are disclosable under the law and timeframes for reporting and updating information.

The second major incomplete component of the ACA nursing homes legislation is initiation of a system to collect and report accurate staffing information from payroll records and other auditable sources. Development of the system was begun more than a decade ago and made mandatory by the ACA, but CMS has been unable to complete protocols to collect the data and report it to the public within ACA timelines. Although CMS is currently testing a reporting system, hours of care and turnover and retention rates are not expected to be collected and reported for two or more years. As a result, *Nursing Home Compare* and other government reporting systems do not have reliable information about nurse staffing, one of the most critical determinants of nursing home quality.

Finally, there are not yet implementing regulations for compliance and ethics programs or improvements in state agency complaint procedures. Several provisions enacted in the ACA, e.g. the independent informal dispute resolution process, residents' rights in the case of facility closure, and reporting of suspected crimes against residents, require either final regulations or better guidance to protect residents. In addition, half of states have not applied for funds to set up criminal background check programs in spite of CMS's efforts to facilitate full participation.

These new ACA initiatives are expected to have a substantial impact on improving the transparency of nursing homes and their accountability for the quality of care they provide.

This issue brief was prepared by Janet Wells, Long-Term Care Consultant, Washington, DC and Charlene Harrington from the University of California, San Francisco (UCSF) for the Kaiser Family Foundation's Commission on Medicaid and the Uninsured.

Endnotes

¹ CMS, “National Health Expenditures Historical Data for 2010.” <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html> and <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/tables.pdf>.

² Ochinko, Walter, Assistant Director, Health Care Team, GAO, *Nursing Home Quality: Findings from GAO Reports*, Presentation to the National Health Policy Forum, March 25, 2010. http://www.nhpf.org/library/handouts/Ochinko.slides_03-25-10.pdf. Typical reports included *Efforts to Strengthen Federal Enforcement Have Not Deterred Some Homes from Repeatedly Harming Residents*, GAO-07-241, Mar 26, 2007; *Federal Monitoring Surveys Demonstrate Continued Understatement of Serious Care Problems and CMS Oversight Weaknesses*, GAO-08-517, May 9, 2008. *Despite Increased Oversight, Challenges Remain in Ensuring High-Quality Care and Resident Safety*, GAO-06-117, Dec 28, 2005.

³ OIG, *Nursing Home Enforcement: Collection of Civil Monetary Penalties*, OEI-06-03-00420, July 2005. <https://www.oig.hhs.gov/oei/reports/oei-06-03-00420.pdf>.

⁴ HHS, *2008 Agency Financial Report*, Sec. III-23. <http://www.hhs.gov/afr/2008sectiii.pdf>.

⁵ Harrington, Charlene, et al., *Ownership, Financing, and Management Strategies of the Ten Largest For-Profit Nursing Home Chains in the United States*, *International Journal of Health Services*, Vol. 41, Number 4 - 2011.

⁶ Duhigg, Charles, “At Many Nursing Homes, More Profit and Less Nursing,” *New York Times*, September 23, 2007. <http://www.nytimes.com/2007/09/23/business/23nursing.html?pagewanted=all&r=0>.

⁷ GAO, *Nursing Homes: Complexity of Private Investment Purchases Demonstrates Need for CMS to Improve the Usability and Completeness of Ownership Data*, GAO-10-710, September 2010. <http://www.gao.gov/assets/320/310562.pdf>

⁸ Subcommittee on Oversight and Investigations, Committee on Energy and Commerce, U.S. House of Representatives, “Trends in Nursing Home Ownership and Quality,” Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, November 15, 2007; “Nursing Home Transparency and Improvement,” Special Committee on Aging, United States Senate, November 15, 2007; and “In the Hands of Strangers: Are Nursing Home Safeguards Working?,” May 15, 2008.

⁹ GAO, *Nursing Homes: Complexity of Private Investment Purchases Demonstrates Need for CMS to Improve the Usability and Completeness of Ownership Data*, GAO 10-710, September 2010. <http://www.gao.gov/assets/320/310562.pdf>.

¹⁰ Federal Register Vol. 76, No. 88 (May 6, 2011), p. 26406

¹¹ Federal Register Vol. 76, No. 152 (August 8, 2011), p. 48510.

¹² The National Consumer Voice for Quality Long-Term Care, Comments to CMS, “Proposed Rule on Disclosure of Ownership and Additional Disclosable Parties,” June 27, 2011.

¹³ <http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol3/pdf/CFR-2011-title42-vol3-sec424-516.pdf>

¹⁴ Ownership data is collected electronically through PECOS or on a paper form, CMS 855A.

¹⁵ See <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html> and <http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855a.pdf>, Section 5 and Section 6.

¹⁶ Centers for Medicare & Medicaid Services (CMS). 2001. *Appropriateness of minimum nurse staffing ratios in nursing homes. Report to Congress: Phase II Final. Volumes I to III*. Baltimore: CMS (prepared by Abt Associates).

¹⁷ *Prudent Action for the FY 2012 Medicare Survey & Certification Budget*, Memo from Thomas E. Hamilton, Director, CMS Survey and Certification Group, to State Survey Agency Directors, December 9,

2011. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/SCLetter12_12.pdf

¹⁸ CMS, *2012 Nursing Home Action Plan: Action Plan for Further Improvement of Nursing Home Quality*. <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Downloads/2012-Nursing-Home-Action-Plan.pdf>.

¹⁹ Edelman, Toby, *Medicare Reimbursement for Skilled Nursing Facilities Remains High for 2011 Despite Reductions in Overpayments*, Center for Medicare Advocacy, August 25, 2011. <http://www.medicareadvocacy.org/2011/08/25/medicare-reimbursement-for-skilled-nursing-facilities-remains-high-for-2010-despite-reductions-in-overpayments/>.

²⁰ American Health Care Association, “CMS Issues Final Rule on Medicare Payments to SNFs,” Press Release, July 29, 2011. http://www.ahcancal.org/News/news_releases/Pages/CMSIssuesFinalRuleonMedicarePaymentstoSNFs.aspx.

²¹ “Trends in Nursing Home Ownership and Quality,” Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, November 15, 2007; “Nursing Home Transparency and Improvement,” Special Committee on Aging, United States Senate, November 15, 2007; and “In the Hands of Strangers: Are Nursing Home Safeguards Working?,” Subcommittee on Oversight and Investigations, Committee on Energy and Commerce, U.S. House of Representatives, May 15, 2008.

²² MedPAC, *Report to the Congress, Medicare Payment Policy*, Chapter 7, March 2012. http://www.medpac.gov/documents/Mar12_EntireReport.pdf.

²³ Harrington, Charlene, et al., *Ownership, Financing, and Management Strategies of the Ten Largest For-Profit Nursing Home Chains in the United States*, International Journal of Health Services, Volume 41, Number 4 -- 2011.

²⁴ Eljay LLC, *A Report on Shortfalls in Medicaid Funding for Nursing Home Care*, American Health Care Association, December 2011. http://www.ahcancal.org/research_data/funding/Documents/Eljay%20Medicaid%20Shortfalls%20Report%202011.pdf.

²⁵ MedPAC, *Report to the Congress, Medicare Payment Policy*, Chapter 7, March 2012. http://www.medpac.gov/documents/Mar12_EntireReport.pdf.

²⁶ Harrington, Charlene, “Trends in Nursing Home Ownership and Quality,” Testimony, U.S. House of Representatives Committee on Ways and Means, Subcommittee on Health, November 15, 2007.

²⁷ Available at <http://www.medicare.gov/NursingHomeCompare/search.aspx>.

²⁸ GAO, *Nursing Homes: More Reliable Data and Consistent Guidance Would Improve CMS Oversight of State Complaint Investigations*, GAO-11-280, April 2011. <http://www.gao.gov/assets/320/317514.pdf>.

²⁹ MDS 3.0, implemented in October 2010, is the current version.

³⁰ See <https://data.medicare.gov/browse?tags=nursing+home>

³¹ GAO, *Nursing Homes: More Reliable Data and Consistent Guidance Would Improve CMS Oversight of State Complaint Investigations*, GAO-11-280, April 2011. <http://www.gao.gov/assets/320/317514.pdf>.

³² OIG, *Nursing Homes under Quality of Care Corporate Integrity Agreements*, Appendix C HHS, April 2009, <https://oig.hhs.gov/oei/reports/oei-06-06-00570.pdf>.

³³ Testimony of Lewis Morris, Office of Counsel to the Inspector General, U.S. Department of Health and Human Services, to the U.S. House of Representatives Committee on Energy and Commerce, Subcommittee on Oversight and Investigations, May 15, 2008. <https://oig.hhs.gov/testimony/docs/2008/testimony051508.pdf>.

³⁴ Federal Register Vol. 76, No. 22 (Feb. 2, 2011), p. 5942.

³⁵ Federal Register Vol. 65, No. 52 (March 16, 2000), page 14289, and Federal Register Vol. 73, No. 190 (September 30, 2008), p. 56832.

³⁶ OIG, *Fiscal Year 2012 Work Plan*. <https://oig.hhs.gov/reports-and-publications/archives/workplan/2012/Work-Plan-2012.pdf>.

³⁷ <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions-Items/Survey-and-Cert-Letter-13-05.html>

³⁸ <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-12-38.pdf>.

³⁹ GAO, *Efforts to Strengthen Federal Enforcement Have Not Deterred Some Homes from Repeatedly Harming Residents*, GAO-07-241, March 2007. <http://www.gao.gov/new.items/d07241.pdf>.

⁴⁰ GAO, *Nursing Homes: Addressing the Factors Underlying Understatement of Serious Care Problems Requires Sustained CMS and State Commitment*, GAO-10-70, November 2009. <http://www.gao.gov/new.items/d1070.pdf>.

⁴¹ OIG, *Nursing Home Enforcement: The Use of Civil Monetary Penalties*, OEI-06-02-00720, April 2005. <https://www.oig.hhs.gov/oei/reports/oei-06-03-00420.pdf>.

⁴² Edelman, Toby, *Nursing Home Decisions of the Department of Health and Human Services' Departmental Appeals Board, 2007*, Center for Medicare Advocacy, May 2008. "Despite the seriousness of the failures in care and the modesty of the enforcement consequences, nursing facilities chose to pursue these cases through the administrative appeals process. The report reveals that in almost all cases, the facilities lost. CMS's decision to cite deficiencies and impose remedies was upheld in 66 of the 71 decisions (93%). At the Appellate Division, CMS won all 18 cases decided on the merits (100%); at the Civil Remedies Division, 48 of 53 cases decided on the merits (90%)." http://www.medicareadvocacy.org/InfoByTopic/SkilledNursingFacility/SNF_08_05.13.DABNursingHomeDecisions.pdf.

⁴³ GAO, *Nursing Home Recommendations, CMS's Response, and the Current Implementation Status, as of September 2010*. Unpublished Report.

⁴⁴ Long Term Care Community Coalition, *Funding for Innovation: A Review of State Practices with Civil Monetary Penalties*, 2006. http://www.nursinghome411.org/CMPPProject/FundingInnov06b_c.pdf.

⁴⁵ Federal Register Vol. 76, No. 53 (March 18, 2011), p. 15106

⁴⁶ Hamilton, Thomas E., Director, Survey and Certification Group, CMS, *Federal Requirements for the Independent Informal Dispute Resolution Process for Nursing Homes - Interim Advance Guidance*, December 2, 2011. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/SCLetter12_08.pdf.

⁴⁷ Hamilton, Thomas E., Director, Survey and Certification Group, CMS, *Use of Federally Imposed Civil Monetary Penalty (CMP) Funds by States*, Memorandum to State Survey Agency Directors, December 16, 2011. http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/SCLetter12_13.pdf.

⁴⁸ Federal Register Vol. 76, No. 34 (February 18, 2011), p. 9503.

⁴⁹ Hamilton, Thomas E., Director, Survey and Certification Group, CMS, *Final Rule for Skilled Nursing Facilities (SNF) and Nursing Facilities (NF) - "Notification of Facility Closure Centers for Medicare and Medicaid Services (CMS)-3230-IFC,"* April 1, 2011. http://www.dhs.wisconsin.gov/rl_dsl/listservPub/attch11_18_01.pdf

⁵⁰ Institute of Medicine, *Retooling for an Aging America: Building the Health Care Workforce*, Consensus Report, April 2008. <http://www.nap.edu/catalog/12089.html>.

⁵¹ Khatutsky, Galina, et al., *Understanding Direct Care Workers: A Snapshot of Two of America's Most Important Jobs - Certified Nursing Assistants and Home Health Aides*, U.S. Department of Health and Human Services, March 2011. <http://aspe.hhs.gov/daltcp/reports/2011/CNAchart.pdf>.

⁵² American Health Care Association, *Nursing Facility Staffing Survey 2010*, October 2011. http://www.ahcancal.org/research_data/staffing/Documents/REPORT%20OF%20FINDINGS%20NURSING%20FACILITY%20STAFFING%20SURVEY%202010.pdf.

⁵³ Aronovitz, Leslie G., Director, Health Care-Program Administration and Integrity Issues, GAO, "Nursing Homes: Many Shortcomings Exist in Efforts to Protect Residents from Abuse," Testimony before the Special Committee on Aging, U.S. Senate, March 4, 2002. <http://www.gao.gov/new.items/d02448t.pdf>.

⁵⁴ OIG, *Nursing Facilities' Employment of Individuals with Criminal Convictions*, OEI-07-09-00110, March 2011. <https://oig.hhs.gov/oei/reports/oei-07-09-00110.pdf>.

⁵⁵ "Building on Success: Lessons Learned from the Federal Background Check Pilot Program for Long-Term Care Workers," Prepared for the Majority Staff of the Senate Special Committee on Aging, July 30, 2008. Committee Print. <http://www.gpo.gov/fdsys/pkg/CPRT-110SPRT43176/html/CPRT-110SPRT43176.htm>. Also see *Evaluation of the Background Check Pilot Program: Final Report*, Prepared by Abt Associates and University of Colorado at Denver and Health Sciences Center for CMS, August 2008.

⁵⁶ See <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-13-06.pdf>

⁵⁷ GAO, *Nursing Homes: More Can Be Done to Protect Nursing Home Residents from Abuse*, GAO-02-312, March 2002. <http://www.gao.gov/new.items/d02312.pdf>.

⁵⁸ Hamilton, Thomas E., Director, CMS Survey and Certification Group, "Reporting Reasonable Suspicion of a Crime in a Long-Term Care Facility," Memorandum to State Survey Agency Directors, June 17, 2011 (revised January 20, 2012).

⁵⁹ Paraprofessional Healthcare Institute, "Direct-Care Workforce at a Glance." <http://phinational.org/direct-care-workers-glance>.

1330 G STREET NW, WASHINGTON, DC 20005
PHONE: (202) 347-5270, FAX: (202) 347-5274
WEBSITE: WWW.KFF.ORG/KCMU

This publication (#8406) is available on the Kaiser Family Foundation's website at www.kff.org.



The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.