

**Testimony of**  
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**Before the**  
**Senate Special Committee on Aging**  
**on**  
**The 20<sup>th</sup> Anniversary of OBRA '87:**  
**Nursing Home Quality, Staffing and Enforcement Issues**  
**May 2, 2007**

Chairman Kohl, Senator Smith and distinguished Members of the Committee, thank you for inviting me to discuss the quality of care provided by nursing homes across our nation upon the 20th anniversary of the Omnibus Budget Reconciliation Act (OBRA) of 1987. This sweeping legislation ushered in a series of landmark nursing home reform initiatives designed to significantly improve quality of care, a high priority for the Administration, the Department of Health and Human Services, and the Centers for Medicare & Medicaid Services (CMS). In 2007, about 3 million elderly and disabled Americans will receive care in nearly 16,000 Medicare- and Medicaid-certified nursing homes. About 1.4 million Americans reside in the nation's 16,000 nursing homes on any given day. And, more than 3 million Americans rely on services provided by a nursing home at some point during the year.

Our nation is aging. This reality shapes the public discourse, looms large in our public imagination, and affects our everyday lives—as families struggle to care for aging parents and other relatives who are living longer, but often with co-existing and chronic health conditions and increasingly complex medical needs. As increasing numbers of our nation's baby boom generation retire, the need for high-quality nursing home care will grow precipitously. According to the National Health Statistics Group in the CMS Office of the Actuary, State and Federal governments paid roughly 62.3 percent of total nursing home care costs in calendar year (CY) 2005, the latest period for which complete data are available. Among the larger nursing

home companies, Medicare beneficiaries typically account for 14 percent of a given facility's population, while Medicaid beneficiaries typically account for 65 percent of residents. CMS is committed to working with its sister agencies, other departments and Congress to ensure that America's elderly and disabled receive the high quality care they need and deserve.

Today, twenty years after OBRA '87, I would like to briefly review where we have been on the nursing home quality front; to describe in greater detail how we have progressed since the reforms' 1990 implementation – especially in terms of reporting, oversight and enforcement – and finally, to highlight our plan of action for 2007 and beyond.

### **QUALITY AND SAFETY COMPLIANCE UNDER OBRA '87**

Improving the safety and quality of nursing home care has been the focus of considerable legislative and regulatory attention. Titles XVIII and XIX of the Social Security Act established minimum statutory requirements with regard to resident health and safety, which all nursing homes participating in Medicare and Medicaid, respectively, must meet. In OBRA '87, Congress articulated additional requirements to protect residents against problems like preventable pressure sores, weight loss and accidents. To help ensure compliance with these new federal requirements, OBRA '87 required Congress to issue a range of sanctions for underperforming nursing homes. These included *civil money penalties* (CMPs) and *denials of payment for new admissions* (DPNAs), which accounted for 80 percent of federal sanctions between fiscal years 2000 and 2005. Other sanctions short of termination – for example, directed plans of correction or in-service training, state monitoring and temporary management – can provide incentives for maintaining compliance, impact a facility's revenues, and even compel closure.

More than 4,000 Federal and state surveyors conduct routine inspections of nursing homes to assess whether they are consistently meeting federal quality and safety requirements. By law, these 'standard surveys' occur no less than once every 15 months, and on average, every twelve months. Complaint investigations, conversely, focus on specific allegations regarding resident care or safety and may stem from complaints lodged by residents, family members, or nursing

home employees. Deficiencies are defined as the gap between the nursing home requirements and a nursing home's actual practice. They are categorized according to severity – from minimal harm to immediate jeopardy – and scope – from isolated to widespread. When state surveyors identify deficiencies, facilities are required to prepare a plan of action to correct the problem or problems. State surveyors document how effectively facilities follow-through with their plan of correction through review of acceptable evidence or an on-site visit. Nursing homes are considered 'noncompliant' until they either achieve substantial compliance by correcting the deficiencies or are terminated from Medicare and Medicaid participation.

Since 1998, CMS has been posting the survey results for standard surveys as well as complaint investigations for individual nursing homes, on its publicly searchable *Nursing Home Compare* website. In addition, *Nursing Home Compare* offers pertinent information on facility characteristics to help consumers make informed decisions. State survey agencies enter the relevant information into CMS' Online Survey, Certification, and Reporting (OSCAR) database and provide updates, as appropriate. The data on the Web site pertaining to quality measures originate from clinical data submitted electronically by the individual nursing homes as part of the Minimum Data Set (MDS). The MDS is collected at regular intervals for every resident in a Medicare- or Medicaid-certified nursing home and addresses factors like residents' health, physical functioning, mental status and general well-being. Regulations require that an MDS assessment be performed at admission, quarterly, annually and whenever the resident experiences a significant change in status. While every attempt is made to assure the accuracy and timeliness of the posted information, the Agency advises consumers to supplement the data with information from the ombudsman's office, state agencies, and other public sources.

To address underperformance among individual nursing homes, CMS may level a CMP or DPNA. Agency regulations specify two types of civil money penalties. A per-day CMP can range from \$50 to \$10,000, depending on whether a case is of the 'non-immediate jeopardy' or 'immediate jeopardy' variety. A per-instance CMP can range from \$1,000 to \$10,000 per episode of non-compliance. Denials of payment for new admissions (DPNAs) make up a substantial number of federal remedies. CMS is permitted by statute to deny payment for existing nursing home residents, as well; however, this type of payment denial is far less

common. CMS regulations require that nursing homes be notified at least 15 days in advance of the imposition of all sanctions, except CMPs. The requirement for advance notice is shortened to two days in cases where deficiencies have been judged to pose immediate jeopardy to the health and safety of residents. If a nursing home can correct the cited deficiencies during the advance-notice period, a DPNA is not imposed. If the facility chooses to appeal the imposition of a DPNA, denial of payment is *not* deferred until such appeals are resolved. CMS is also authorized to impose discretionary DPNA's and terminations in situations not explicitly cited, so long as facilities are given the appropriate notice.

CMS takes four factors into account when imposing sanctions on a nursing home: (1) the scope and severity of the deficiency, (2) prior compliance history, (3) desired corrective action and long-term compliance, and (4) the number and severity of deficiencies overall. In general, the severity of the sanction increases with the severity of the deficiency. For example, in cases of 'immediate jeopardy,' temporary management, termination or both are required and CMPs permitted. For deficiencies falling in the middle of CMS' scope and severity scale – at the level of 'actual harm' – temporary management, a DPNA, a CMP, or a combination thereof, is required. DPNA's are imposed when nursing homes fail to comply with program participation regulations within three months of the noncompliance finding. Termination from the program is the result when nursing homes fail to achieve compliance within six months of the noncompliance finding. Significantly, the statute stipulates that CMS act on deficiencies in a way that minimizes the time between identification and imposition of the sanctions.

Finally, the Federal government and the states share responsibility for enforcement of nursing home quality-of-care requirements. In general, sanctions are initially proposed by state surveyors based on cited deficiencies; then reviewed, imposed, and ultimately put into effect by CMS regional offices.

### **CMS INITIATIVES TO ENSURE NURSING HOME QUALITY**

The most effective approach to ensuring quality is one that mobilizes all available tools and aligns them in a comprehensive strategy. CMS' action plan for 2007 and beyond consists of five inter-related and coordinated approaches:

**Consumer Awareness and Assistance**—The elderly, disabled and their friends and families must be active, informed participants in ensuring the quality of their care in any healthcare system. The availability of relevant, timely information is critical because it sets the stage for holding the healthcare system accountable for the quality of services it provides. To that end, CMS is committed to continually updating and expanding the resources and information provided on [www.Medicare.gov](http://www.Medicare.gov) and *Nursing Home Compare*. The Agency is exploring options for the refinement of a nurse-staffing quality measure to better account for case-mix and risk-adjustment. Currently, each nursing home is required to report its nursing staff hours to the state survey agency. CMS uses the data to report total nursing staff hours *per resident, per day*; drilling down further to identify per-resident, per-day staff hours by Registered Nurse (RN), Licensed Practical and Vocational Nurse (LPN/LVN) and Certified Nursing Assistant (CNA). While instructive, these figures do not *necessarily* reflect the number of nursing staff present at any given time or the amount of care given to any one resident. While at present, there is no Federal standard for specific levels of nurse staffing in a nursing home, CMS requires nursing homes to employ sufficient staff to adequately care for all residents.

**Survey, Standards, and Enforcement Processes**—This year, CMS is rolling out numerous initiatives to improve the effectiveness of surveys and the management and follow-through of complaint investigations. Since problems may occur between routine surveys, complaint investigations allow surveyors and CMS to assess whether nursing homes are consistently promoting and protecting the health, safety, and welfare of residents. CMS continues to require that State survey agencies use a national, electronic tracking system that monitors the processing and investigation of complaints from intake to resolution. Outcome data is now available across provider and supplier types. CMS prioritizes the concerns of nursing home residents and family members, and is committed to responding to them in a timely manner. Nearly 12,000 more complaint investigations were conducted by the Agency and the States in 2005 than were conducted in 1999.

For the last few years, nursing homes with the worst quality-of-care track records – dubbed ‘Special Focus Facilities’ (SFFs) – have been subject to more frequent surveys and decisive punitive action if significant improvements are not achieved and sustained. As a result of this

program, many nursing homes have been induced to operate within federal requirements. . In 2005 CMS expanded the number of ‘Special Focus Facilities’ by 35 percent. The President’s proposed budget for survey and certification in 2008 will enable CMS to explore expanding the program as it applies to nursing homes and improving on the quality care they offer the nation’s most vulnerable populations.

CMS has also taken great care in updating its interpretive guidance for nursing home surveyors, focusing first on requirements that relate to quality of care and quality of life. This updated guidance supports a nationally consistent application of the survey process in evaluating facilities for compliance with nursing home requirements, based on current standards of practice and investigative protocols.

Lastly, CMS continues to make improvements to its survey process. Since the inception of OBRA’87 there have been several improvements, including using national quality data in focusing on quality problems. CMS is in the midst of a pilot of the QIS survey process – a computer assisted survey system that shows promise in increasing consistency and more objective documentation. However, expansion of this survey process will largely rely on increased resources to implement this program nationally.

**Quality Improvement**—CMS continues to zero-in on reducing the use of restraints and the incidence of pressure sores, which compromise the health and well-being of a significant number of nursing home residents. The Agency also acknowledges the current ‘culture change’ movement and echoes OBRA principles of knowing and respecting each nursing home resident to better provide individualized care and enhance quality of life. The concept of ‘culture change’ encourages facilities to change outdated practices, allows residents more input in and control over their own care, and encourages staff to be more responsive to individual resident needs. Further, by requiring nursing homes to offer residents influenza and pneumococcal vaccine, the Agency is helping to ensure the health of residents while setting the stage to report facility-level immunization rates and immunization measures for compliance and quality comparison.

**Quality Through Partnerships**—CMS’ Quality Improvement Organizations (QIOs), state

survey agencies, non-governmental organizations and others are committed to strengthening their partnership and continuing to coordinate their education and enforcement activities to achieve lasting improvements in nursing home care. CMS is part of a national nursing home quality campaign – Advancing Excellence in America’s Nursing Homes. This campaign brings together 18 national organizations representing consumers, nurse clinicians, medical directors, provider organizations, unions, foundations, and Quality Improvement Organizations. Nursing homes, consumers, and organizations can sign up to work on eight goals ranging from reducing pressure sores to reducing unnecessary restraints. To date nearly 3,500 nursing homes have signed up. Also, this year, CMS will translate national goals regarding restraint use and pressure sore incidence into their regional equivalents; improve its follow-up with States, and analyze the relevant data to generate state- and facility-specific rates.

## **CONCLUSION**

Mr. Chairman, thank you for the opportunity to testify on the quality of care in our nation’s nursing homes. With our combined efforts and continued vigilance, I am confident we will continue to see improvements on this critical front. I look forward to answering your questions.