

Protecting Seniors by Improving -- Not Eroding -- Nursing Home Quality Standards

Briefing Hosted by the Seniors Task Force

June 4, 2018

- | | | |
|------|---|--|
| I. | Introductions & Background | Janet Wells
Consultant
California Advocates for Nursing Home Reform
202-550-0209
janetwells.dc@gmail.com
www.canhr.org |
| II. | Nursing Home Quality, Oversight Staffing | Richard Mollot
Executive Director
Long Term Care Community Coalition
212-385-0355
richard@ltccc.org
www.ltccc.org |
| III. | Enforcement of Nursing Home Standards & Federal/State Role in Ensuring Competent, Financially Sound Owners/Managers | Toby Edelman
Senior Policy Attorney
Center for Medicare Advocacy
202-293-5760
tedelman@medicareadvocacy.org
www.medicareadvocacy.org |
| IV. | Nursing Home and Financial Accountability Issues | Charlene Harrington
Professor
University of California – San Francisco
415-269-4080
Charlene.Harrington@ucsf.edu |
| V. | Policy Recommendations: What Congress Can Do | Robyn Grant
Director of Public Policy and Advocacy
National Consumer Voice for Quality Long-Term Care
202-332-2275; ext 205
rgrant@theconsumervoice.org
www.theconsumervoice.org |

Table of Contents

Introduction and Background	3
Nursing Home Quality, Oversight, and Staffing	6
Statement for Briefing on Nursing Home Care, Quality, and Staffing.....	10
Nursing Home Review.....	18
Recent Articles and Accounts of the Nursing Home Industry Under the Trump.	22
Enforcement of Nursing Home Standards and Federal/State Role in Ensuring Competent, Financially Sound Owners/Managers	30
Deregulating Nursing Homes	34
Buying and Selling Nursing Homes: Who's Looking Out for the Residents?	37
Nursing Home and Financial Accountability Issues.....	40
Financial and Accountability Issues.....	44
Policy Recommendations: What Congress Can Do	47
Policy Recommendations to Protect Nursing Home Residents	50

PROTECTING SENIORS

By Improving – Not Eroding –
Nursing Home Quality Standards

Seniors Task Force
June 4, 2018

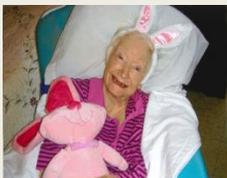
INTRODUCTION

Today's discussion is about . . .

- Existing laws and regulations that protect nursing home residents and why they are important
- The essential role of nurse staffing in ensuring quality care
- Why federal oversight and enforcement are necessary
- How nursing homes are operated and financed and the role of Medicare and Medicaid
- Why the Trump administration's rollback of nursing home regulation threatens seniors
- Measures to improve quality and resident protections and what Congress can do

Washington Post, May 1, 2018

She modeled in New York and worked for the Navy. At 93, parasites ate her alive at a nursing home.



Rebecca Zeni's Life

"Her beauty could capture a room."

- Rebecca Zeni was described as a "modern-day woman of the 1940s and 1950s. Headstrong, career-oriented and hard-working."
- After high school, she became a Navy employee at the Norfolk naval base.
- Later she moved to New York City and became a model.
- In New York, she also worked as an assistant to Mike Wallace at CBS News.
- Then she became a mother and homemaker.
- At 93, she had Alzheimer's disease and had been living for 5 years in a Georgia nursing home that was undergoing repeated outbreaks of scabies.

Rebecca Zeni's Death

"an agonizing death . . . in constant pain"

- Scabies is highly contagious. Parasites burrow under the skin and lay eggs – in Ms. Zeni's case, throughout her body. Her family's lawyer said she was "literally being eaten alive."
- Scabies spreads through human contact or touching surfaces handled by someone who has it. Residents with scabies at Ms. Zeni's nursing home weren't quarantined. Staff who had it weren't required to stay home. Sheets slept on by infected residents were washed with the rest of the linens.
- As many as 20 residents and staff may have been infected. During another scabies outbreak at the facility, a total of 35 staff and residents contracted the disease.

Kaiser Health News – Dec. 22, 2017

Infection lapses are rampant in nursing homes, but punishment is rare.

Infections are a dangerous problem throughout the healthcare system. They are especially prevalent in nursing homes.

- Basic steps to prevent infections – such as handwashing – are routinely ignored.
- 74% of nursing homes have been cited for infection control lapses.
- Only 1 in 75 received high-level citations that would lead to penalties.



Nursing Home Quality, Oversight & Staffing

Presented by Richard Mollot
 Long Term Care Community Coalition
richard@ltccc.org 212-385-0355
www.nursinghome411.org

+ Though Care Has Improved, Serious Problems Persist – and Need Our Attention

- While nursing home care has improved since the scandalous conditions that led to the 1987 Nursing Home Reform Law, abuse, neglect, and substandard care persist.
- Hundreds of thousands of residents, in facilities across the country, are impacted every day.
- **New research and public data indicate that substandard care, resident abuse, and neglect may be more serious and widespread than previously understood.**
- **Congressional action is needed to...**
 - Stop further degradation of nursing home safety standards;
 - Ensure that CMS and the State Agencies are fulfilling their mission to protect residents and hold providers accountable for substandard care; and
 - Institute reasonable restraints to prevent bad actors from draining money and resources allocated to provide resident care.

Too often, "Buyer Beware" Defines the Experience of Nursing Home Residents & Families.

+ Nursing Home Quality and Enforcement

HHS OIG: Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries

- An astonishing one-third of residents who went to a nursing home for short-term care were harmed within an average of 15.5 days.
- Close to 60% of that harm was preventable and likely attributable to poor care.

+ Nursing Home Quality and Enforcement

LTCCC Study of State Survey Agency Performance

In 2015, LTCCC published the first ever (to our knowledge) report on state survey agency performance that focused on resident-level, rather than facility-level, quality assurance.

We looked at three areas identified as key to quality and program integrity:

- Pressure Ulcers
- Antipsychotic Drugging
- Staffing



4

+ Nursing Home Quality and Enforcement

Pressure Ulcers

- CDC: "[p]ressure ulcers are serious medical conditions and one of the important measures of the quality of clinical care in nursing homes."
- Clinical Journal: While some pressure ulcers are unavoidable, research and experience indicate that, "[i]n the vast majority of cases, appropriate identification and mitigation of risk factors can prevent or minimize pressure ulcer (PU) formation."
- Nevertheless, pressure sores remain a significant, often horrifying, problem for too many of our nursing home residents.
 - 7.5% of residents (over 95,000 individuals) have unhealed pressure ulcers (2018).
 - Though pressure ulcers are largely preventable, states cite nursing homes the equivalent of less than 3% of the time that a resident has a pressure ulcer.
 - When states *do* cite a facility for inadequate pressure ulcer care or prevention, they only identify this as harmful to residents about 25% of the time.

5

+ Nursing Home Quality and Enforcement

Antipsychotic Drugging

- Inappropriate antipsychotic drugging is a serious and widespread problem in nursing homes across the United States. Antipsychotics are extremely dangerous, particularly for elderly individuals with dementia. They are indicated only for certain clinical conditions. They are not indicated for so-called dementia behaviors.
- Too many residents receive these drugs as a form of chemical restraint, and as a substitute for good care.
- In 2012, the HHS Inspector General stated, in regard to the "overmedication of nursing home patients" that the "[g]overnment, taxpayers, nursing home residents, as well as their families and caregivers should be outraged - and seek solutions."
- Nevertheless, inappropriate antipsychotic drugging continues to be a significant and acute problem in too many nursing homes:
 - 20% of residents (over 250,000 individuals) are currently receiving these drugs.
 - Less than 2% of the population will ever have a diagnosis for which CMS risk-adjusts for potentially appropriate use of antipsychotic drugs.
 - 0.31% – the average state citation rate for inappropriate drugging (2015).
 - 2% – the percent of these citations identified as causing resident harm.

6

+ Nursing Home Quality and Enforcement

Staffing

- Though sufficient staff is acknowledged as critical to good care, and insufficient staffing is known to be a widespread problem, insufficient staffing is rarely cited.
- The annual rate of staffing deficiencies per resident is infinitesimal: 0.036%.
- Less than 5% of those deficiencies are identified as having caused resident harm.

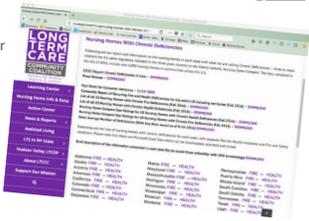
The benefits of higher staffing levels, especially RNs, include lower mortality rates; improved physical functioning; less antibiotic use; fewer pressure ulcers, catheterized residents, and urinary tract infections; lower hospitalization rates; and less weight loss and dehydration.
- Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2009 Through 2016.

+ Nursing Home Quality and Enforcement

LTCCC Report: *Chronic Deficiencies in Care: The Persistence of Recurring Failures to Meet Minimum Safety & Dignity Standards in U.S. Nursing Homes*

2017

- “Chronic deficiencies” -- three or more citations for the same health or safety standard in a three-year period.
- Our analysis of three years’ of data posted on Nursing Home Compare found that an astonishing 42% of nursing homes had chronic deficiencies.



Too often, serious problems continue for years while residents, rather than operators, pay the price for substandard care.

+ Nursing Home Staffing

In November 2017, fulfilling an Affordable Care Act mandate, CMS made available, for the first time, auditable, payroll-based data on nursing home staffing.

New Data

What do the data show?

- Care Staff vs. Administrative Staff
- Weekdays vs. Weekends & Holidays
- Required RN Coverage

What do the data indicate?

Insufficient Staffing Widespread:

- **82% of nursing homes report total direct care staffing at 4.0 hours per resident day or less.** A landmark federal study in 2001 indicated that 4.1 hours of direct care staff time is typically needed to meet a resident’s clinical needs.
- **30% of nursing homes report total direct care staffing of 3.0 hours per resident day or less.**

LONG TERM CARE COMMUNITY COALITION

Advancing Quality, Dignity & Justice

STATEMENT FOR BRIEFING ON:
NURSING HOME CARE, QUALITY, AND STAFFING
JUNE 4, 2018

PRESENTED BEFORE:
HOUSE OF REPRESENTATIVES
CONGRESSIONAL TASK FORCE ON SENIORS
CHAIRMAN JOE CROWLEY
VICE CHAIR LINDA T. SÁNCHEZ

PRESENTED BY:
RICHARD J. MOLLOT
EXECUTIVE DIRECTOR
LONG TERM CARE COMMUNITY COALITION
RICHARD@LTCCC.ORG
WWW.NURSINGHOME411.ORG

Table of Contents

I. Introduction	3
II. Quality & Enforcement Trends	4
HHS OIG: One-Third of Medicare Short-Term Rehab Residents Harmed	4
LTCCC Study of State Survey Agency Performance	4
1. Pressure Ulcers	4
2. Antipsychotic Drugging	5
3. Staffing	5
LTCCC Report: Chronic Deficiencies	6
III. Nursing Home Staffing	6
Background	6
New Data	6
1. Insufficient Staffing Widespread	6
2. RN Staffing of Particular Concern	7
IV. Selected Recommendations	7
Attention Must Be Paid	7
Mandate Minimum Safe Staffing Levels	7
Ensure Imposition of Meaningful Penalties for Abuse & Neglect	7
Increase Transparency of Nursing Home Ownership	8
Place Limits on Unbridled Profits & Non-Care Related Expenses	8
Informed Written Consent for Antipsychotic Drugs	8
Bolster the Voice of Residents and Families	8
V. Conclusion	8

The Long Term Care Community Coalition

One Penn Plaza, Suite 6252

New York, NY 10119

Phone: 212-385-0355

Twitter: twitter.com/LTCconsumer

Facebook: facebook.com/ltccc

Visit our website, www.nursinghome411.org, for quality, enforcement and other data on nursing homes in every state, as well as resources for residents, families, and other stakeholders.

I. Introduction

Thank you for the opportunity to speak with you today.

My name is Richard Mollot. I am the executive director of the Long Term Care Community Coalition (LTCCC). LTCCC is a non-profit organization dedicated to improving care and quality of life for residents in nursing homes and assisted living. LTCCC focuses on systemic advocacy, conducting research on LTC issues to identify the root causes of problems and develop practicable recommendations to address them. To support our mission we work with – and endeavor to educate and engage – residents and families as well as organizations and individuals representing the interests of the elderly and disabled.

Nursing home residents are among our most vulnerable citizens. By definition, they require 24-hour a day monitoring and care. For these reasons, there are federal standards to ensure that residents are protected and receive the care and services they need to attain their highest practicable medical, emotional and social well-being.

While there are efforts underway to help people access long term care services outside of nursing homes, nursing homes will always provide critical services, particularly as our citizens age and more people live longer with dementia and other chronic conditions. In fact, recent research indicates that over half of people who reach their late 50s will need nursing home care at some point. In addition to the substantial public need for nursing home care, there is a substantial public investment: taxpayers pay for a significant majority of nursing home care.

Thankfully, there are numerous nursing homes that provide good care, treat their residents with dignity and demonstrate a commitment every day to fulfilling the promise they make to residents and families as well as American taxpayers. Unfortunately, too many of our nursing homes fail to take essential resident protections seriously. They take our money every day, and promise to provide good care, but fail to do so.

Today I will provide a brief overview of problems that we and others have identified which indicate that too many of our nursing home residents are not receiving the quality of care which they deserve and for which (for the majority of residents) the public pays. In addition, I will discuss a few recent trends and data on nursing home staffing - the foundation for quality and safety.

Unfortunately, too many of our nursing homes fail to take essential resident protections seriously.

They take our money every day, and promise to provide good care, but fail to do so.

II. Quality & Enforcement Trends

HHS OIG: One-Third of Medicare Short-Term Rehab Residents Harmed

A 2014 Office of Inspector General study, *Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries*,¹ found that an astonishing one-third of residents who went to a nursing home for short-term care were harmed within an average of 15.5 days, and that almost 60% of that harm was preventable and likely attributable to poor care.

This is particularly striking because Medicare reimbursement rates are extremely high. The Medicare Payment Advisory Commission (MedPAC) has reported that nursing homes are overpaid by the Medicare program and have enjoyed Medicare margins exceeding 10% for more than 14 consecutive years.² Why don't nursing homes take care of these highly profitable patients? What are the implications for our elderly residents, particularly the majority of residents who have dementia?

LTCCC Study of State Survey Agency Performance

In 2015, LTCCC published the first ever (to our knowledge) report on state survey agency performance that focused on resident-level, rather than facility-level, quality assurance.³ Generally, quality measures and citations are viewed in respect to facilities. From our perspective, this misses the point: quality – and quality assurance – should focus on the lives of the residents who entrust nursing homes with their care.

Following are highlights of our findings on the three criteria which we identified as being important indicators of nursing home quality and safety.

1. Pressure Ulcers

- According to the U.S. Centers for Disease Control & Prevention (CDC), “[p]ressure ulcers are serious medical conditions and one of the important measures of the quality of clinical care in nursing homes.”⁴
- While some pressure ulcers are unavoidable, research and experience indicate that, “[i]n the vast majority of cases, appropriate identification and mitigation of risk factors can prevent or minimize pressure ulcer (PU) formation.”⁵

¹ Available at <https://oig.hhs.gov/oei/reports/oei-06-11-00370.asp>. Six percent of those who were harmed died, and more than half were rehospitalized.

² See <http://www.medpac.gov>.

³ *Safeguarding NH Residents & Program Integrity: A National Review of State Survey Agency Performance*, LTCCC (2015), <http://nursinghome411.org/national-report-safeguarding-nursing-home-residents-program-integrity/>.

⁴ NCHS Data Brief, No. 14 (February 2009), which incorporates *Pressure Ulcers Among Nursing Home Residents: United States, 2004*. Available at www.cdc.gov/nchs/data/databriefs/db14.pdf.

⁵ Edsberg, L.; Langemo, D.; Baharestani, M.; Posthauer, M.; and Goldberg, M., “Unavoidable Pressure Injury: State of the Science and Consensus Outcomes,” *Journal of Wound, Ostomy & Continence Nursing*: July/August 2014 - Volume 41 - Issue 4 - p 313–334. Abstract accessed in February 2017 at http://journals.lww.com/jwoconline/Abstract/2014/07000/Unavoidable_Pressure_Injury_State_of_the_Science.6.aspx.

- Nevertheless, pressure sores remain a significant, often horrifying, problem for too many of our nursing home residents.
 - 7.5% of residents (over 95,000 individuals) have unhealed pressure ulcers (2018).
 - Though pressure ulcers are largely preventable, states cite nursing homes the equivalent of less than 3% of the time that a resident has a pressure ulcer.
 - When states *do* cite a facility for inadequate pressure ulcer care or prevention, they only identify this as harmful to residents about 25% of the time.

In the vast majority of cases, appropriate identification and mitigation of risk factors can prevent or minimize pressure ulcer formation.

2. Antipsychotic Drugging

- Inappropriate antipsychotic drugging is a serious and widespread problem in nursing homes across the United States. Antipsychotics are extremely dangerous, particularly to elderly individuals with dementia. They are indicated only for certain clinical conditions. They are *not* indicated for so-called dementia behaviors.
- Too many residents receive these drugs to make them easier to care for or for other reasons for which there are not clinical indications. Too frequently, these drugs are administered as a form of chemical restraint, and as a substitute for good care.
- In 2012, the U.S. DHHS Inspector General stated, in regard to the “overmedication of nursing home patients” that the “[g]overnment, taxpayers, nursing home residents, as well as their families and caregivers should be outraged - and seek solutions.”⁶ Since that time, the nursing home industry has taken some steps to reduce inappropriate antipsychotic drugging.
- Nevertheless, inappropriate antipsychotic drugging continues to be a significant and acute problem in too many nursing homes:
 - Less than 2% of the population will ever have a diagnosis for which CMS risk-adjusts for potentially appropriate use of antipsychotic drugs.
 - 20% of residents (over 250,000 individuals) are currently receiving these drugs.
- Though CMS promised in 2012 that the state agencies would be stepping up enforcement of protections against chemical restraints and inappropriate drugging, that has not happened.
 - 0.31% – the average state citation rate for inappropriate drugging (2015).
 - 2% – the percent of drugging citations identified as causing resident harm.

3. Staffing

- Though sufficient staff has been identified as critical to good care, and insufficient staffing is known to be a widespread problem, insufficient staffing is rarely cited.
 - The annual rate of staffing deficiencies per resident is infinitesimal: 0.036%.
 - Less than 5% of those deficiencies are identified as having caused resident harm.

⁶ Statement of Daniel R. Levinson, Inspector General, Department of Health and Human Services in respect to the OIG report, *Medicare Atypical Antipsychotic Drug Claims for Elderly Nursing Home Residents*, OEI-07-08-00150 (May 2011). Available at <https://oig.hhs.gov/oei/reports/oei-07-08-00150.pdf>.

LTCCC Report: Chronic Deficiencies

Despite the persistence of substandard care, resident abuse and the provision of “Worthless Services” in too many nursing homes, enforcement is weak in respect to both properly identify problems and holding providers accountable. The result is a self-perpetuating system in which, far too often, residents, families and taxpayers are the losers.

In 2017, LTCCC published a report on facilities with what we identified as “chronic deficiencies” -- three or more citations for the same health or safety standard in a three-year period.⁷ Our analysis of data posted on Nursing Home Compare found that an astonishing 42% of nursing homes had chronic deficiencies.

Nursing Homes
with Chronic
Deficiencies:

42%

III. Nursing Home Staffing

Background

Decades of research have told us what any resident or family member can tell you personally: staffing is key to nursing home quality. Despite this, far too many nursing homes fail to have sufficient – or sufficiently trained – staff. Insufficient staffing is often the underlining issue in nursing home deficiencies, including such serious problems as pressure ulcers⁸ and unnecessary antipsychotic drug use,⁹ because less staffing means less time adequately meeting the needs of residents.

New Data

For many years, the only public information on a nursing home’s staffing was self-reported by facilities and unaudited by either the states or CMS. Thus, we appreciated when an auditable, payroll-based staff reporting system was included in the Affordable Care Act passed by Congress in 2010. In November 2017, the federal Centers for Medicare & Medicaid Services (CMS) released, for the first time, data on nursing home staffing that is based on payroll-based journal (PBJ) reporting. In April 2018, CMS began using these data on Nursing Home Compare, the nation’s premier website for information about a nursing home’s safety, staffing, and quality.

1. *Insufficient Staffing Widespread*

- **82% of nursing homes report total direct care staffing at 4.0 hours per resident day or less.** A landmark federal study indicated that 4.1 hours of direct care staff time is typically needed to meet a resident’s clinical needs.
- **30% of nursing homes report total direct care staffing of 3.0 hours per resident day or less.**

⁷ *Chronic Deficiencies in Care: The Persistence of Recurring Failures to Meet Minimum Safety & Dignity Standards in U.S. Nursing Homes*, LTCCC (Feb. 2017), <http://nursinghome411.org/nursing-homes-with-chronic-deficiencies/>.

⁸ *Issue Alert: Pressure Ulcers*, LTCCC (Oct. 2017), <http://nursinghome411.org/ltccc-issue-alert-pressure-ulcers/>.

⁹ *Issue Alert: Antipsychotic Drugs*, LTCCC (Nov. 2017), <http://nursinghome411.org/issue-alert-antipsychotic-drugs/>.

2. RN Staffing of Particular Concern

Registered nurses are critical to the safety and quality of care provided in a nursing home. They are the only care staff with the licensure and skills to assess residents and provide appropriate supervision of care and services provided to residents.

- **70% of nursing homes report RN care staffing at 0.5 hours per resident day or less.** The landmark study indicated that 0.55 -0.75 is typically needed to meet a resident’s needs.
- CMS “concerned with **recurring instances or aberrant patterns of days with no RN onsite.**”
 - 6% of facilities have 7 or more days where no hours for RNs were reported.
 - 80% of all days with no RN hours were weekend days.
- Some nursing homes have the equivalent of **zero hours of RN care staff per resident per day, every day.**
- **Appropriate staffing is possible!** 25% nursing homes across the country – including for-profit and not-for-profit facilities – provide .55+ hours of RN care staff time per resident day.

Some nursing homes have the equivalent of

zero

hours of RN care staff per resident per day, every day.

IV. Selected Recommendations

Attention Must Be Paid

GAO and other federal reports have played an essential role in improving nursing home care and accountability over the last 40 years and would, undoubtedly, have a critical positive impact now. For example, the HHS Inspector General should follow his 2014 report on Adverse Events for Medicare beneficiaries with one focused on Medicaid beneficiaries who are, generally speaking, far more vulnerable.

Mandate Minimum Safe Staffing Levels

Staffing is perhaps the most critical indicator of a nursing home’s quality and safety. Many nursing homes provide decent staffing but the majority do not. In the absence of a defined requirement, those facilities are unlikely to change their practices.

Ensure Imposition of Meaningful Penalties for Abuse & Neglect

Minimum standards are only meaningful if they are enforced. For too many facilities, it makes financial sense to hire less staff and provide inferior services, since there are minimal (if any) penalties when they fail to provide decent care.

Increase Transparency of Nursing Home Ownership

While the nursing home industry is experiencing unprecedented corporatization, there is little knowledge of, no matter accountability for, how public monies that pay for nursing home care are actually spent.

Place Limits on Unbridled Profits & Non-Care Related Expenses

There are currently no limits in respect to profits taken from a nursing home's operations. Importantly, in respect to both for-profit and non-profit providers, there are no meaningful restrictions in respect to self-dealing, expenses paid for administrative and other (non-care) expenses, rental arrangements for underlying property, etc...

Conversely, there are no requirements that a certain portion of the funds given to nursing homes to provide care are actually used to provide that care. There is no minimum amount that must go to pay care staff, furnish palatable food, or ensure that a facility is clean.

Informed Written Consent for Antipsychotic Drugs

Too many families that we speak to state that their loved one has been given an antipsychotic without their knowledge (no matter their permission). Requiring written permission is a critical, yet easy-to-implement way to address this widespread and dangerous problem.

Bolster the Voice of Residents and Families

Resident and family councils can play an important role in improving conditions in their nursing homes. The new federal regulations for nursing homes foster the role of family and resident councils and also require that every facility have a grievance officer. This does not need to be an additional staff person but, rather, simply someone in the facility to whom residents and families can turn when they have a problem and know that they will receive some kind of response from him or her within a reasonable time frame.

Unfortunately, some in the nursing home industry, including powerful lobbyists at AHCA and LeadingAge, are calling for removal of many basic federal standards. Even the requirement to have a designated grievance officer is under attack.

V. Conclusion

Thank you again for your interest in the well-being of our nursing home residents and for this opportunity to brief you.

Many of our nursing homes do a good job in caring for their residents. However, increasing corporatization, the largely unbridled power of industry lobbyists, and lack of accountability perpetuate a system in which, far too often, it is both acceptable and profitable to provide poor care. We would welcome the opportunity to work with you to ensure that our nursing homes residents are safe and able to live with the dignity that we all desire and deserve.

LONG TERM CARE COMMUNITY COALITION

Advancing Quality, Dignity & Justice

Nursing Home Review

1. WHY DOES NURSING HOME CARE MATTER?

- **People.** Over 1.3 million Americans depend on nursing home care every day. Hundreds of thousands of nurses, social workers, administrative and support staff are employed by US nursing homes.
- **Seniors.** Half of Americans who reach their late 50s will need nursing home care at some point, making the quality and safety of nursing homes a concern to virtually every family at some point.
- **Dementia.** The need for nursing home care is expected to grow due to the aging of the Baby Boomer population, and individuals generally living longer with serious chronic conditions, such as Alzheimer's and other forms of dementia.
- **Money.** The vast majority of nursing homes (96.2%) are dually certified by both Medicaid and Medicare. Approximately 75% of nursing home care is paid for by the public through these programs, making the quality and value of nursing home care of significant public interest.

2. FEDERAL NURSING HOME STANDARDS.

- **Federal Law – Background.** The Nursing Home Reform Law (OBRA '87) was promulgated in 1987 under conditions similar to those Americans face today: increasing reports of substandard care, abuse, and neglect in nursing homes across the country, coupled with a president's attempt to cut safety standards. This led to a public outcry and a federal study which indicated that more, rather than less, protections were needed to ensure that residents receive decent care and can live with dignity.
- **Federal Law – Important Protections.** The Nursing Home Reform Law provides that all residents are entitled to receive the care and services necessary to attain and maintain their highest practicable medical, social, and emotional well-being. Importantly, "highest practicable" means what the individual can achieve with appropriate assistance and care services, not what the facility may deem most practical in respect to maximizing profit margins. In other words, when a facility agrees to admit a resident—whether a frail elderly person who can no longer live safely at home or someone coming in for post-op rehabilitation—the facility is promising that it has the necessary and appropriate staffing and services. In this regard, it is worth noting that nursing home certification is a voluntary contractual relationship in which a nursing home that wishes to provide services to

One Penn Plaza, Suite 6252 New York, NY 10119 P: 212-385-0355 E: info@ltccc.org
www.nursinghome411.org

individuals who need 24/7 skilled nursing care and participate in the Medicare and/or Medicaid programs agrees to provide services that meet (or exceed) minimum requirements.

- **Regulations.** The Reform Law is realized through federal regulations, known as the Requirements for Participation. These Requirements reflect well-established standards of care for the range of services provided by nursing homes, from dementia care and medication management to infection control and prevention. They exist because, in their absence, too many nursing homes were flouting even the most basic, long-recognized safety and dignity standards with impunity.
- **Recent Changes.** To address the universally recognized need to improve nursing home care and safety (see Quality Assurance and Accountability, below), CMS recently undertook a number of changes, including recalibration of regulatory standards and enforcement mechanisms, to better implement the essential standards of the Nursing Home Reform Law. These include:
 - **New Federal Nursing Home Regs** (Requirements for Participation) were promulgated fall 2016. Three phases of implementation: 11/16, 11/17 and 11/19.
 - **New nursing home survey** (for state inspections) introduced 11/17.
 - **New Federal Nursing Home Guidance** (sub-regulatory guidelines) 11/17.
 - **Reporting of Each Nursing Home’s Staffing Levels.** CMS is implementing a payroll-based system for reporting every nursing home’s staffing levels to address widespread problems of inflated numbers (previously, information on nursing home care staff provided to the public was self-reported and unaudited). This important improvement in the veracity of information on facility staffing levels made available to the public is a result of the Affordable Care Act.

3. QUALITY ASSURANCE AND ACCOUNTABILITY.

- **Regulatory Oversight.** The Centers for Medicare & Medicaid Services (CMS) is responsible for quality assurance in all nursing homes. It, in turn, contracts with state Survey Agencies which are supposed to ensure that residents are safe by enforcing regulatory standards. This is, essentially, expected to be accomplished in three ways: facility monitoring, unannounced inspections, and by responding to complaints about care. Fundamentally, a strong and effective nursing home survey and certification system is crucial for current and future nursing home residents, as well as their families. Because residents are often very frail and vulnerable, meaningful oversight and effective enforcement is necessary to ensure that they are safe and able to live with dignity.
- **Substandard Care, Abuse & Neglect Widespread.** Dozens of GAO, HHS Inspector General, and academic studies over the years, as well as our own analyses of federal data, have shown that substandard care, abuse, and neglect are widespread and persistent problems in nursing homes across the United States. Similarly, studies and analyses have systematically indicated that facilities are rarely held accountable in a meaningful way for violations of minimum standards, even when those violations result in resident harm or death.
 - 20% of nursing home residents—approximately 250,000 individuals—are administered antipsychotic drugs, despite the FDA “Black Box” warning that these drugs are highly dangerous and potentially deadly for elderly individuals.

- 7.5% of nursing home residents—approximately 95,000 individuals—have unhealed pressure ulcers, though research indicates that, in the vast majority of cases, appropriate identification and care can prevent or minimize their formation.
 - An astonishing 33% of individuals who go to a nursing home for short-term rehab are harmed within approximately two weeks of entering a facility.
- **Money is Not the Problem.**
- **Nursing Home Reimbursement Rates Are - And Have Long Been – High.** In March 2018, the Medicare Payment Advisory Commission (MedPAC) asked Congress to cut reimbursement rates for skilled nursing facilities, citing high Medicare margins and concerns over therapy services.
 - **Nursing Homes Are Set to Reap a Windfall.** Nursing homes will receive an \$850 million increase in reimbursement this year, plus an estimated \$2 billion in savings over the next ten years under the Patient-Driven Payment Model (PDPM) announced by CMS in April 2018. In addition, according to McKnight’s LTC News (an industry publication), nursing homes will reap a “windfall” as a result of the tax breaks passed this year of \$140,000 in savings for every \$1 million in revenue.
- **Improved Standards and Enforcement Needed.** Accompanying the body of evidence that far too many elderly and disabled residents receive substandard care is the body of data indicating that, though the Nursing Home Reform Law is strong, monitoring is weak and enforcement mechanisms are woefully under-utilized. [LTCCC’s 2015 study on nursing home oversight](#), utilizing federal data, found that:
- Only 3.4% of all health violations are identified as having caused any harm to a resident. This is critical because, in the absence of a finding of harm, it is highly unlikely that a facility will face any penalty. [See the [Elder Justice Newsletter](#) at <http://nursinghome411.org/news-reports/elder-justice/> for a monthly selection from the 96.6% of deficiencies cited as “no-harm” which, upon review, appear to have resulted in often serious resident harm.]
 - Though over 20% of residents (at the time of the study) were administered dangerous antipsychotic drugs, the average state citation rate for inappropriate drugging was 0.31%. This indicates that there is a significant amount of inappropriate antipsychotic drugging that is not being cited by the states.
 - Though pressure ulcers are largely preventable, states cite nursing homes the equivalent of less than 3% of the time that a resident has a pressure ulcer. When States do cite a facility for inadequate pressure ulcer care or prevention, they only identify this as harmful to residents about 25% of the time.
- **CMS Moving in Wrong Direction on Safety Standards and Oversight.**
- **Diminished Penalties.** CMS is adopting the provider industry’s request to limit (already small) penalties for substandard care, abuse and neglect.
 - **Reduced Standards.** CMS, at the industry’s request, is delaying enforcement of basic standards relating to dementia care, safe use of antibiotics, and baseline care plans for individuals entering a facility for a full 18 months (50% more than industry lobbyists requested in writing).
 - **Nursing Home Industry as “Partner” and “Customer.”** CMS now openly refers to the nursing home industry as its customers, and the industry’s interests—rather than those of elderly and disabled residents—as those which it is working to protect.
 - **Mandatory Arbitration.** In its 2016 Requirements for nursing homes, CMS prohibited pre-dispute arbitration agreements. In response to industry pressure, CMS issued a new

notice of proposed rule-making (NPRM) to not only allow nursing homes to put pre-dispute arbitration clauses in residency agreements but to also allow them to require signing such an agreement as a condition of admission.

- **Grievance Officer and Policies.** The 2016 Requirements mandate that every nursing home have an assigned grievance officer who must be responsive to resident and family complaints and concerns. LTCCC considers this to be an important provision since it, minimally, provides a chain of accountability for residents and families. In 2017, CMS issued a NPRM to weaken the requirements on having a designated grievance officer, record-keeping about complaints and more.
- **Grave Concerns About the Future.**
- CMS has announced that it is planning to once again revise the nursing home standards in summer 2018. This will, undoubtedly, put residents in jeopardy and further undermine the integrity of the Medicare and Medicaid programs, which pay for most nursing home care.
 - LTCCC is also concerned that CMS may be moving toward permitting nursing homes to choose private accreditation over government surveys.

Resources

1. Data sources for this brief include:
 - a. [Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2009 Through 2016](https://www.kff.org/medicaid/report/nursing-facilities-staffing-residents-and-facility-deficiencies-2009-through-2016/), Charlene Harrington, Helen Carrillo, Rachel Garfield, and Ellen Squires (Kaiser Family Foundation, April 2018). Available at <https://www.kff.org/medicaid/report/nursing-facilities-staffing-residents-and-facility-deficiencies-2009-through-2016/>.
 - b. [CDC National Center for Health Statistics: Nursing Home Care](https://www.cdc.gov/nchs/fastats/nursing-home-care.htm), <https://www.cdc.gov/nchs/fastats/nursing-home-care.htm>.
 - c. LTCCC's website, www.nursinghome411.org (see below for more information).
2. [Long Term Care Community Coalition \(www.nursinghome411.org\)](http://www.nursinghome411.org) - LTCCC's home page provides information on staffing levels, quality measures, and enforcement for all licensed nursing homes in the US. The website also has a primer on nursing home care standards and a variety of fact sheets and resources for the public.
3. [Nursing Home Compare \(www.medicare.gov/nursinghomecompare/\)](http://www.medicare.gov/nursinghomecompare/). The federal website with detailed information on all licensed nursing homes.
4. [Center for Medicare Advocacy \(http://www.medicareadvocacy.org/\)](http://www.medicareadvocacy.org/).

LONG TERM CARE COMMUNITY COALITION

Advancing Quality, Dignity & Justice

Recent Articles and Accounts of the Nursing Home Industry Under the Trump Administration: Greater Influence, Diminished Safety Standards & Accountability

The nursing home industry and its principal lobbyists, the American Healthcare Association (AHCA) and LeadingAge, have, for generations, characterized reimbursement as being insufficient to provide better staffing and services, and safety standards as being too onerous to abide. Nevertheless, the profitization of the industry has increased over the years, with a growing percentage of US nursing homes being purchased and operated by for-profit entities and the growth of nursing home chains, which have largely corporatized nursing home care.

Importantly, this approach has been adopted by many non-profit facilities and chains, with operations too often tailored to maximizing income and minimizing spending on staffing and resident services (rather than being driven to fulfill a mission related to the common good). Across the board, there are increasing reports of individual facilities and chains – both for-profit and non-profit – monetizing nursing home property and operations to such an extent that even basic services are unsustainable.

In short, our residents and their care are, increasingly, being monetized at great public expense and, too often, personal tragedy. This is affecting vulnerable individuals, their families, and communities in every state. Action is needed to “right the ship” – push back on efforts to reduce accountability for resident safety and dignity and for the efficient, appropriate use of the taxpayer funds, which pay for the majority of nursing home care.

Following are excerpts from some recent articles which bely the industry’s claims that it is under-paid and over-regulated.

McKnight’s LTC News (provider industry publication and news source): “We're shocked — shocked! — that bribery is going on here” (April 30, 2018)

<https://www.mcknights.com/daily-editors-notes/were-shocked-shocked-that-bribery-is-going-on-here/article/761529/>

Fortunately, this field is well represented when it comes to a lobbying presence in the nation's capital. By all accounts, the American Health Care Association and LeadingAge are plugged in.

They know the lever movers, have developed solid relationships with them (and their people) and consistently motivate providers to stay in touch.

American Healthcare Association (AHCA) 2017 Annual Report

https://www.ahcancal.org/News/publication/Documents/AHCA_AnnualReport2017.pdf

- WE WERE A POWERFUL POLITICAL VOICE: Met our goal of raising \$3.735 million in hard dollars and \$1.8 million in soft dollars
- Hosted more than 200 events with members of Congress
- Litigated for a reversal of the ban on arbitration agreements
- Skilled nursing providers received a 1.0% increase, the highest amount providers could receive under current law
- Worked closely with CMS to gain regulatory relief
- Application of daily, retroactive fines was discontinued

McKnight's LTC News: "Providers rewarded for sticking with it" (May 2, 2018)

<https://www.mcknights.com/daily-editors-notes/providers-rewarded-for-sticking-with-it/article/762772/>

[M]ake no mistake: There has been [some very good](#) going on for providers lately.

I put Friday's unveiling of a new resident classification system and a 2.4% Medicare pay hike at the top of the list. ... The administration, in fact, says its new proposal will bring providers \$2 billion in savings in soft costs over 10 years.

[P]roviders should take pride in the fact that federal regulators seem to have listened (and, oh yes, given them a lot of what they wanted). That's a victory in anybody's book.

Skilled Nursing News: Two articles in one day contrast the current capitulation to industry lobbyists vs. the often devastating impact of inadequate oversight and enforcement. (May 2, 2018)

1. [New Skilled Nursing Payment Plan Shows CMS Listened to Providers](#) - Several experts say that operators should look at the changes as positive updates made with providers in mind, and not a wholesale upheaval of the way they get paid.
2. [Skyline Healthcare Collapsing in South Dakota, Could Dissolve Soon](#) - The South Dakota Department of Health filed a motion for Skyline to turn over its assets and income after residents at its 19 facilities in the state were put at risk.

McKnight's LTC News: "Union officials: Nursing home in bankruptcy raided by federal agents while residents watched" (May 23, 2018)

<https://www.mcknights.com/news/union-officials-nursing-home-in-bankruptcy-raided-by-federal-agents-while-residents-watched/article/767893/>

In 2016, the Labor Department sued the home and Stern, alleging they funneled \$4 million from the facility's retirement plan to themselves and a religious organization.

The Nursing Home Industry Under the Trump Administration: Greater Influence, Diminished Safety Standards & Accountability

The retirement plan was supposed to provide benefits for employees and beneficiaries of both Bridgeport Health Care Center and Bridgeport Manor, located in Bridgeport, CT. Stern was also the plan's trustee and sole decision maker. The feds alleged Stern diverted at least \$4 million in plan assets to Bridgeport Health, himself, and Em Kol Chai, a New York-based religious organization that lists Stern as its president and trustee.

Weller and a small group of the home's 400 or so workers protested there in early April, telling the media employees were not being paid on time or in full. The nursing home filed for bankruptcy April 18.

Centers for Medicare & Medicaid Services (CMS): “CMS Drives Patient-Centered Care over Paperwork in Proposals to Modernize Medicare and Reduce Burden” (April 27, 2018)

<https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2018-Press-releases-items/2018-04-27.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending>

[Quoting CMS Administrator Seema Verma:] “For skilled nursing facilities, we are taking important steps through proposed payment improvements that will reduce administrative burden...” ...In the proposed rules announced today, the agency is also responding to comments from stakeholders and seeking to incorporate its Patients over Paperwork Initiative through avenues that reduce unnecessary burden on providers by easing documentation requirements and offering more flexibility. [Reducing “regulatory burdens,” i.e., minimum care and safety standards, has been a long-time priority for the nursing home industry, which has ramped up its efforts in this regard since the 2016 presidential election.]

Becker’s Hospital Review: “CMS reduces penalties for medical errors at nursing homes: 5 things to know” (December 26, 2017)

<https://www.beckershospitalreview.com/post-acute-care/cms-reduces-penalties-for-medical-errors-at-nursing-homes-5-things-to-know.html>

Under President Donald Trump, CMS has softened penalties against nursing homes for patient safety errors, according to [*The New York Times*](#).

Here are five things to know.

1. The relaxing of these penalties occurred over the course of President Trump's first year in office. In October, for example, CMS discouraged its regional offices from issuing fines for one-time mistakes at nursing homes, even if the error contributed to the death of a patient. However, the agency maintained nursing homes should still be fined for systemic errors and errors resulting from intentional harm.
2. The changes in regulatory enforcement have been welcomed by industry groups such as the American Health Care Association, which argued the penalties under President Barack Obama were overly punitive and did not focus on helping nursing homes improve care.
3. In July, CMS instructed state agencies to cease the issuance of daily fines for safety violations in nursing homes that happened prior to an inspection. These fines were originally meant to

The Nursing Home Industry Under the Trump Administration: Greater Influence, Diminished Safety Standards & Accountability

spur urgent solutions to safety issues, but they became purely disciplinary instead of corrective when issued after the error had already been resolved or addressed by the nursing home, according to David Gifford, senior vice president for quality with the AHCA.

"What was happening is you were seeing massive fines accumulating because they were applying them on a per-day basis retrospectively," Mr. Gifford told the *Times*.

4. However, these changes could protect nursing homes from maximum fines for even the most harmful errors. For example, now shuttered Lincoln Manor in Decatur, Ill., was fined \$282,954 in September 2016 after staff failed to treat a patient whose implanted pain medication pump ruptured through her abdomen over the span of eight days. The patient eventually died. It took the facility 28 days after the error to retrain nurses so a similar event wouldn't occur. Under the new penalties, the facility would have been fined less than \$21,000, according to the *Times*.

5. Advocates for nursing home residents say the regulatory changes could undo progress made to reduce errors in these facilities. Janet Wells, a consultant for California Advocates for Nursing Home Reform, told the *Times* the changes have come at a time when "some egregious violations and injuries to residents are being penalized — finally — at a level that gets the industry's attention and isn't just the cost of doing business."

To read the full article from *The New York Times*, [click here](#).

Skilled Nursing News: CMS Overhauls Skilled Nursing Payment Plan, Increases Rate by \$850 Million (April 27, 2018)

<https://skillednursingnews.com/2018/04/cms-overhauls-skilled-nursing-payment-plan-increases-rate-850-million/>

The Centers for Medicare & Medicaid Services (CMS) on Friday unveiled a new proposed model for skilled nursing reimbursements that the agency says will save providers \$2 billion over the next decade. ... CMS framed the move as a concession to providers based on feedback regarding RCS-I [Resident Classification System, Version 1]....

...In the same swoop, CMS also released payment rate changes for fiscal 2019 under the new rule: SNFs will see a boost of \$850 million in Medicare money based on a market basket update of 2.4%. Had CMS not taken that step, as mandated by the Bipartisan Budget Act of 2018, the increase would have been closer to \$670 million.

Pittsburgh Post-Gazette: Squirrel Hill nursing home's fine in bed rail strangulation case reduced by \$219,750 (April 27, 2018)

<http://www.post-gazette.com/local/city/2018/04/27/Charles-Morris-nursing-home-Pennsylvania-Health-Department-fine-reduced-Robert-Frankel-strangulation/stories/201804270147>

The nursing home had appealed the original \$235,000 fine the state imposed in December for circumstances surrounding the death of prominent Pittsburgh businessman and philanthropist Robert Frankel. A settlement agreement dated March 28 and provided by the department Friday indicated the fine had been reduced to \$15,250.

The Nursing Home Industry Under the Trump Administration: Greater Influence, Diminished Safety Standards & Accountability

“Through the appeal process, the penalty was reduced to focus on the most egregious deficiency (or deficiencies) identified,” department spokeswoman April Hutcheson said in an email when asked for explanation of the reduction.

The original fine, one of the largest penalties in the state agency’s history of nursing home regulation, followed an investigation of the Sept. 17 death of Mr. Frankel, 89, the father of state legislator Dan Frankel of Squirrel Hill.

Mr. Frankel, who had both mental and physical impairments, died from asphyxiation in the middle of the night when his neck was trapped in a bed rail. Due to the risk of such entrapment, federal guidelines call for such railings to be used as a last resort in long-term care facilities, following careful assessment of the patient’s condition and a doctor’s authorization of their necessity....

McKnight’s LTC News: Aria faces allegations of 'gross self-dealing' in Arkansas bankruptcy case (May 10, 2018)

Aria Health Group and its owners participated in “gross self-dealing and corporate wrong” by transferring money from debtors it controlled to itself in the months before and after those companies filed for bankruptcy in 2016, a federal complaint alleges.

The claim was brought by James Dowden, a Chapter 7 bankruptcy trustee for Highlands Arkansas Holding, who argued in filings that his client and its affiliates were compelled to make double payments disguised as “special rent” and repayment of capital advances to Aria even as they petitioned for bankruptcy.

In all, Dowden alleges some \$5.1 million in questionable transfers were made in the year leading up to bankruptcy. Had they not been made, that money would have been part of the bankruptcy estate for the debtors (HAH).

“Despite making inconsistent, late or no payment to their landlords and other vendors for the duration of the operation of the Arkansas Facilities, the HAH Subsidiaries made numerous repayments of working capital advances to Aria,” court documents state.

HAH also made management or other payments — nearly \$570,000 worth— to Aria after the bankruptcy filing date, Dowden’s attorney alleges.

“There can be no plausible business justification for such transfers,” he wrote.

US HHS 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 (August 24, 2017)

<https://oig.hhs.gov/oas/reports/region1/11700504.pdf>

We identified 134 Medicare beneficiaries whose injuries may have been the result of potential abuse or neglect that occurred from January 1, 2015, through December 31, 2016. We also found that a significant percentage of these incidents may not have been reported to law enforcement. As a result, we determined that CMS has inadequate procedures to ensure that

The Nursing Home Industry Under the Trump Administration: Greater Influence, Diminished Safety Standards & Accountability

incidents of potential abuse or neglect of Medicare beneficiaries residing in SNFs are identified and reported. Accordingly, this Early Alert contains suggestions for immediate actions that CMS can take to ensure better protection of vulnerable beneficiaries.

In addition, our prior audit reports showed that group homes did not report up to 15 percent of critical incidents to the appropriate State agencies. Our preliminary results combined with these prior report results raise significant concerns that incidents of potential abuse or neglect at SNFs have gone unreported.

Skilled Nursing News: Why ManorCare's Former CEO is Owed Millions After Bankruptcy (March 19, 2018)

<https://skillednursingnews.com/2018/03/manorcares-former-ceo-owed-millions-bankruptcy/>

Unfunded pension obligations are behind a multi-million-dollar payout due to HCR ManorCare's former president and CEO — even though the company has filed for Chapter 11 bankruptcy.

Paul Ormond, who left ManorCare in September 2017, is owed \$116.7 million under the prepackaged bankruptcy plan by which Quality Care Properties, Inc. (NYSE: QCP) will take over the Toledo, Ohio-based skilled nursing provider.

Reuters: ManorCare wins court approval to exit bankruptcy under landlord (April 13, 2018)

<https://www.reuters.com/article/us-hcrmanorcare-bankruptcy-quality-care/manorcare-wins-court-approval-to-exit-bankruptcy-under-landlord-idUSKBN1HK27C>

No. 2 U.S. nursing home chain HCR ManorCare Inc won court approval on Friday for a plan to exit a \$7.1 billion Chapter 11 bankruptcy by transferring ownership to its landlord, Quality Care Properties Inc ([QCP.N](#)).

U.S. Bankruptcy Judge Kevin Gross in Delaware approved the prepackaged reorganization that will give Quality Care, with 10 employees and \$318 million in annual revenue, control over ManorCare.

Toledo, Ohio-based ManorCare has more than 50,000 employees in more than 450 senior living facilities and clinics across the country, with annual revenue of \$3.7 billion.

The takeover ends a rocky chapter in the chain's history following its purchase by private equity fund Carlyle Group... for \$6.3 billion in 2007 just before the financial crisis. Carlyle spun off ManorCare's real estate to Quality Care's predecessor HCP Inc...for \$6.1 billion in 2010 to unlock value.

For HCP, the deal put what Chief Executive Jay Flaherty called "a winner" into the portfolio. He assured investors that 3.5 percent **rental bumps on an already above-market lease would "fund an awful lot of dividend increases over the next 25 years."**

But a year after signing the master lease on 289 facilities, ManorCare's revenues were failing to cover monthly rent, according to court papers. When it filed for bankruptcy in March, it owed Quality Care \$446 million in rent that was accruing at a minimum of \$39.5 million every month. [Emphases added.]

McKnight's LTC News: At least 9 lawsuits against SNFs on hold as a result of Orianna bankruptcy (April 16, 2018)

<https://www.mcknights.com/news/at-least-9-lawsuits-against-snfs-on-hold-as-a-result-of-orianna-bankruptcy/article/758639/>

A bankruptcy filing by Tennessee-based Orianna Health Systems has put at least nine wrongful death lawsuits against the company's nursing homes on hold indefinitely.

"They are stopped in their tracks," Lee Cope, a Hampton attorney handling two of the cases, told the [Anderson \(South Carolina\) Independent Mail](#).

The nine cases all involve former residents in upstate South Carolina. Orianna, operated by 4 West Holdings, has a total of 42 nursing homes across seven states. The company filed for bankruptcy in March, citing previous court payouts of \$6.5 million as one of the reasons for its financial struggle.

The newspaper reported **Orianna plans to sell its South Carolina and Georgia facilities under terms of a restructuring agreement. The remaining 23 could be transferred to its landlord, Omega Healthcare Investors.**

Orianna had planned to [protect whoever acquires its facilities from its current liabilities](#). But the Centers for Medicare & Medicaid Services earlier this week said that would be against Medicare rules.

And so **families in South Carolina wait anxiously to see if and when their cases can proceed.** [Emphases added.]

McKnight's LTC News: Florida-based Avante Group to sell nearly half its nursing homes in two-state deal with Sentosa Care (April 20, 2018)

<https://www.mcknights.com/news/florida-based-avante-group-to-sell-nearly-half-its-nursing-homes-in-two-state-deal-with-sentosa-care/article/759884/>

The Avante Group is planning to exit the North Carolina market and reduce its presence in Virginia, having reached a deal with New York-based Sentosa Care LLC for 10 skilled nursing facilities. For-profit Sentosa Care, founded in 2003, bills itself as the "fastest growing group of nursing facilities" in the New York metropolitan region. It is now New York's largest nursing home network. **Sentosa was the target of a scathing 2015 ProPublic report that [questioned why officials in New York had failed to pressure operators to improve quality](#)** before being allowed to expand. [Emphasis added.]

U.S. House of Representatives, Cttee. On Energy & Commerce: Letter to CMS Administrator Verma (April 2, 2018)

<https://energycommerce.house.gov/wp-content/uploads/2018/04/20180402CMS.pdf>

The committee has been closely following recent media reports describing horrific instances of abuse, neglect, and patient harm allegedly occurring at SNFs and NFs across the country,

The Nursing Home Industry Under the Trump Administration: Greater Influence, Diminished Safety Standards & Accountability

including at the Rehabilitation Center at Hollywood Hills where 14 residents died in the immediate aftermath of Hurricane Irma in Florida. These reports raise serious questions about the degree to which the Centers for Medicare and Medicaid Services (CMS) is fulfilling its responsibility to ensure federal quality of care standards are being met, as well as its duty to protect vulnerable seniors from elder abuse and harm in facilities participating in the Medicare and Medicaid programs. The adequacy of the CMS' oversight of SNFs and NFs has also been called into question in recent reports issued by the Office of Inspector General at the U.S. Department of Health and Human Services (HHS OIG) and the U.S. Government Accountability Office (GAO).

Briefing Paper: Why Were One-Third of SNF Patients in the Inspector General's Study Harmed? (February 13, 2017)

<http://nursinghome411.org/consumer-response-to-oig-adverse-events-study/>

An Office of Inspector General study, *Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries* (February 2014), found that one-third of residents who were in a skilled nursing facility (SNF) for short-term care were harmed, and that almost 60 percent of the injuries were preventable and attributable to poor care. As a result, six percent of those who were harmed died, and more than half were rehospitalized at an annualized cost of \$2.8 billion in 2011. Why is the rate of substandard care so high in nursing homes?

Reimbursement Was Not to Blame – Medicare Payments Were Unusually High

MedPAC reported that SNF reimbursement rates were unusually high in 2011, the year of the OIG study: "Increases in payments between 2010 and 2011 outpaced increases in providers' costs, reflecting the continued concentration of days in the highest payment case-mix groups. In addition, payments in 2011 were unusually high because of overpayments resulting from an adjustment made to implement the new case-mix groups. Because Medicare cost reports were not available in time for this report, we estimated a range for the 2011 margins: from 22 percent to 24 percent. This year is the 11th year in a row with Medicare margins above 10 percent." – MedPAC: *Report to the Congress, Medicare Payment Policy*, March 2013, Chapter 8, Skilled nursing facility services. [The actual margin, reported in MedPAC's March 2014 report to Congress, was 21 percent.]

CENTER FOR MEDICARE ADVOCACY, INC.

**ENFORCEMENT OF NURSING HOME
STANDARDS & FEDERAL/STATE
ROLE IN ENSURING COMPETENT,
FINANCIALLY SOUND OWNERS &
MANAGERS**

June 4, 2018

www.medicareadvocacy.org
Copyright © Center for Medicare Advocacy, Inc.

ENFORCEMENT

- Nursing Home Reform Law (1987) requires
 - Range of remedies/sanctions (civil money penalties, denial of payment for new or all admissions, directed plan of correction, monitor, termination from Medicare and Medicaid programs).
 - Use of more significant remedies for more serious, uncorrected, and repeated deficiencies.

www.medicareadvocacy.org
Copyright © Center for Medicare Advocacy, Inc.

2

**IMPLEMENTATION OF
ENFORCEMENT**

- Historically, enforcement has been weak.
- Regulations categorize deficiencies by scope (number of residents affected) and severity (seriousness).
- More than 95% of deficiencies are called “no-harm.”
- The result: Financial remedies are rarely imposed.

www.medicareadvocacy.org
Copyright © Center for Medicare Advocacy, Inc.

3

MYTH OF BURDENSOME REGULATIONS

- Most problems in care (deficiencies) are not cited and, if cited, are not enforced with financial penalties. Generally, only the most serious deficiencies are likely to have any sanctions imposed.
- Small penalties are “cost of doing business.”
- When enforcement is so rare, the regulations cannot fairly or accurately be described as burdensome.

www.medicareadvocacy.org
Copyright © Center for Medicare Advocacy, Inc.

4

TRUMP ADMINISTRATION WEAKENED ENFORCEMENT

- Through subregulatory guidance (Survey & Certification Letters addressed to state survey agencies); no public notice or comment
 - Per instance CMPs made default (reversing Obama Administration guidance, 2014, that made per day CMPs the default) (Jul. 2017)
 - Maximum per instance CMP is \$20,965; per day CMPs have no dollar limit.

www.medicareadvocacy.org
Copyright © Center for Medicare Advocacy, Inc.

5

SMALLER AND FEWER CIVIL MONEY PENALTIES IMPOSED

- 2016 (full fiscal year, Oct. 2015-Sep. 2016):
 - 1728 per day CMPs (average \$53,845.66)
 - 942 per instance CMPs (average \$3,161.93)
- 2017 (full fiscal year (Oct. 2016-Sep. 2017):
 - 1923 per day CMPs (average \$71,581.52)
 - 2147 per instance CMPs (average \$6,969.83)
- 2018 (Oct. 1, 2017 - May 7, 2018)
 - 310 per day CMPs (average \$84,887.71)
 - 721 per instance CMPs (average \$10,057.49)

www.medicareadvocacy.org
Copyright © Center for Medicare Advocacy, Inc.

6

OTHER CHANGES TO ENFORCEMENT

- Begin fines at time of survey (not earlier, even when noncompliance began earlier).
- Proposed changes (Oct. 2017) include:
 - Limiting CMPs for immediate jeopardy (highest level of noncompliance) if “one-time mistake” or no “intent” to harm.
 - Uncoupling scope and severity of deficiencies from remedies.

www.medicareadvocacy.org
Copyright © Center for Medicare Advocacy, Inc.

7

CHANGING NURSING HOME INDUSTRY

- Originally, individually and locally owned
- With Medicare and Medicaid reimbursement, shift to for-profit ownership
- Multi-state chains
- Private equity firms bought chains
 - Chains and private equity firms separated ownership and management; multiple companies involved.

www.medicareadvocacy.org
Copyright © Center for Medicare Advocacy, Inc.

8

RECENT UPHEAVALS IN NURSING HOME INDUSTRY

- Landlords (real estate investment trusts) forced chains into bankruptcy (e.g., HCR ManorCare)
- Chains shifting their focus, owning the property and buildings, but transferring management to unknown operators

www.medicareadvocacy.org
Copyright © Center for Medicare Advocacy, Inc.

9

SKYLINE

- Unknown New Jersey company; bought 110 facilities in 6 states since 2015.
- Between end of March 2018 and end of April 2018, Skyline stopped meeting payroll and paying vendors.
- States went to court to take over the facilities to protect residents.

www.medicareadvocacy.org
Copyright © Center for Medicare Advocacy, Inc.

10

CONCERNS ABOUT SHIFTS IN OWNERSHIP/MANAGEMENT

- Insufficient state and federal oversight of new owners/managers
 - California State Auditor's recent report finds state does not follow its own rules on relicensing facilities.
 - Vermont law calls for review of state oversight, especially financial issues and owners of real estate.

www.medicareadvocacy.org
Copyright © Center for Medicare Advocacy, Inc.

11

CENTER FOR MEDICARE ADVOCACY, INC.

www.medicareadvocacy.org

www.medicareadvocacy.org
Copyright © Center for Medicare Advocacy, Inc.

Deregulating Nursing Homes

by Toby S. Edelman



In lockstep with the nursing home industry, the Trump Administration is rapidly dismantling the regulations and guidance that have been developed over the past 30 years to implement and enforce the federal Nursing Home Reform Law.¹ Until the Christmas Eve 2017 report in *The New York Times*,² these devastating changes, often made without any public notice or comment, received no public attention.

The single deregulatory issue in the nursing home area that attracted any public concern was the Trump Administration's proposed rule³ that would reverse the Obama Administration's 2016 final rule prohibiting nursing homes from using pre-dispute mandatory arbitration provisions in their

admissions contracts with residents.⁴ The Trump rule has not yet been issued in final form.

Although litigation is an important tool when residents are seriously harmed or killed by poor care, the regulatory system is intended to prevent avoidable bad outcomes in the first place.⁵ It is the regulatory system, and particularly, at this time, the enforcement system, that is under severe attack.

The 1987 Nursing Home Reform Law, signed by President Reagan as part of the Omnibus Budget Reconciliation Act, has three broad components. First, it sets federal standards of care, called Requirements of Participation, for skilled nursing facilities and nursing facilities

1) 42 U.S.C. §§1395i-3(a)-(h), 1396r(a)-(h), Medicare and Medicaid, respectively.

2) Jordan Rau, "Trump Administration Eases Nursing Home Fines in Victory for Industry," (Dec. 24, 2017), *The New York Times*, <https://www.nytimes.com/2017/12/24/business/trump-administration-nursing-home-penalties.html>.

3) 82 Fed. Reg. 26649 (Jun. 8, 2017).

4) 42 C.F.R. §483.70(n); adopted by 81 Fed.Reg. 68688, 68790-68800 (Oct. 4, 2016).

5) *Kizer v. City of San Mateo*, 806 P.2d 1353 (1991) (rejecting the claim that a personal injury lawsuit is an adequate substitute for pre-injury enforcement by a public agency and describing the state police power to protect public health).

that voluntarily choose to participate in (and receive reimbursement from) the Medicare and Medicaid programs. Second, it establishes a survey system with unannounced on-site visits by trained health care professionals to determine compliance with those standards. And third, it establishes a range of intermediate sanctions, or penalties, that may be imposed when a facility fails to meet the standards of care for any, some, or all residents. Most of the remedies are discretionary.

Through subregulatory guidance – that is, guidance below the level of regulations that is implemented without notice and comment rulemaking under the Administrative Procedures Act – the Centers for Medicare & Medicaid Services (CMS) has essentially eviscerated the enforcement system.

In July 2017, CMS issued guidance to surveyors that reduced the amounts of civil money penalties (CMPs) that could be imposed against facilities,⁶ expressly replacing guidance issued by the Obama Administration in 2014.⁷ The 2017 guidance makes lower per instance CMPs the default, rather than higher per day CMPs; it discourages the Regional Offices (ROs) that officially impose remedies from starting per day CMPs before “the start date of the survey” (a change that especially affects problems identified as a result of complaint surveys); it requires CMS’s Central Office to review CMPs exceeding \$250,000; and it expands facilities’ ability to describe CMPs as unaffordable, among other changes that reduce CMP amounts.

6) CMS, “Revision of Civil Money Penalty (CMP) Policies and CMP Analytic Tool,” S&C: 17-37-NH (Jul. 7, 2017), (Memorandum from David R. Wright, Director, Survey and Certification Group, to State Survey Agency Directors), <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-37.pdf>.

7) CMS, “Civil Money Penalty (CMP) Analytic Tool and Submission of CMP Tool Cases,” S&C: 15-16-NH (Dec. 19, 2014) (Memorandum from Thomas E. Hamilton, Director, Survey and Certification Group, to State Survey Agency Directors), <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-15-16.pdf>.

On October 27, 2017, CMS proposed repealing and replacing⁸ surveyor guidance that the Obama Administration issued in July 2016.⁹ Remarkably, the American Health Care Association (AHCA), the large nursing home trade association, had explicitly requested replacement of the Obama guidance, which it identified by number, in its December 2016 letter to President-Elect Trump.¹⁰ AHCA repeated the request in a March 9, 2017 letter to then-HHS Secretary Tom Price.¹¹ The proposed 2017 guidance calls for limiting the imposition of CMPs for immediate jeopardy deficiencies (the highest of four levels of severity by which deficiencies are classified) that reflect a “one-time mistake” or that do not reflect “intent” to harm; prohibits imposition of CMPs for “past noncompliance;” uncouples scope and severity of deficiencies from particular remedies; and reduces enforcement against the one or two worst facilities in each state that are designated as Special Focus Facilities.¹²

Other changes to enforcement are planned. CMS officials told state survey agency directors in August 2017 that CMS is evaluating additional regulatory policies, including “[m]ultiple tags for same noncompliance (AKA ‘stacking’)” – that

8) CMS, “Revised Policies regarding the Immediate Imposition of Federal Remedies – FOR ACTION,” S&C: 18-01-NH (Oct. 27, 2017), <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-18-01.pdf>.

9) CMS, “Mandatory Immediate Imposition of Federal Remedies and Assessment Factors Used to Determine the Seriousness of Deficiencies for Nursing Homes,” S&C: 16-31-NH (Jul. 22, 2016), revised 7.29.16, <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-16-31.pdf>.

10) <http://www.ihca.com/Files/Comm-Pub/AHCAN-CAL-Letter-TrumpAdmin-Attachments.pdf>.

11) <http://www.ihca.com/Files/Comm-Pub/AHCA-Final-Price-Ltr-3.9.17.pdf>.

12) CMS, The Special Focus Facility (‘SFF’) Initiative, <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/downloads/sfflist.pdf>.

is, citing a single deficiency rather than multiple deficiencies when multiple systems fail in a facility – and “[e]xploring improving care through other remedies (e.g., DPOC [directed plans of correction]” – that is, using remedies other than financial penalties, even when deficiencies are cited.¹³

As dismantling of the enforcement system continues,¹⁴ CMS is also delaying enforcement for certain standards of care that were promulgated by the Obama Administration in 2016 as so-called Phase 2 requirements,¹⁵ ended a five-year initiative to reduce the inappropriate use of antipsychotic drugs,¹⁶ solicits changes to revise federal standards of care,¹⁷ and announces plans to revise the requirements in order to reduce provider burden.¹⁸

This is a very dangerous time for residents.

13) CMS Powerpoint at annual meeting of Association of Health Facility Survey Agencies, Slide 41 (Aug. 23, 2017), http://ahfsa.org/resources/Pictures/CMS%20Update_AHF-SA_%20AUG2017-AHFSAonly.pdf.

14) CMS, “Revised Federal Oversight Support Survey (FOSS) Process National Pilot,” Admin. Info. 18:06-NH (Dec. 22, 2017), <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Admin-Info-8-06.pdf> (advising that deficiencies identified in federal surveys will not be cited unless they reflect substandard quality of care, harm, or immediate jeopardy that were not identified by the state survey agency’s survey).

15) CMS, “Revisions to State Operations Manual (SOM) Appendix PP for Phase 2, F-Tag Revisions, and Related Issues,” S&C: 17-36-NH (Jun. 30, 2017), <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-36.pdf>.

16) CMS, “Data show National Partnership to Improve Dementia Care achieves goals to reduce unnecessary antipsychotic medications in nursing homes” Fact Sheet (Oct. 2, 2017), <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-10-02.html>.

17) 82 Fed. Reg. 21014, 21089 (May 4, 2017).

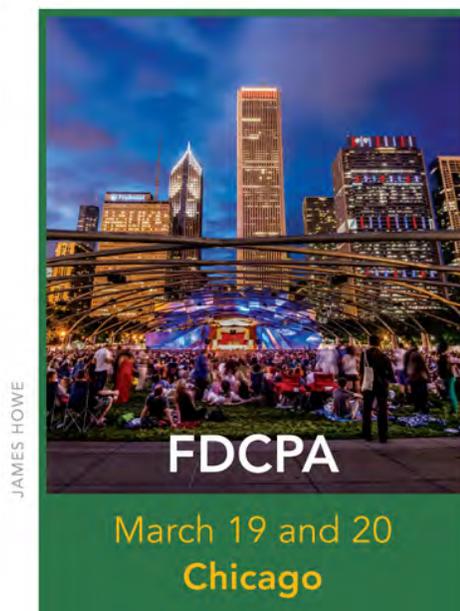
18) CMS, “Requirements for Long-Term Care Facilities: Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction,” CMS-3347-P, <https://www.reginfo.gov/public/do/eAgendaViewRule?pubId=201710&RIN=0938-AT36>.

Residents’ advocates must remain vigilant and vocal.

About the author:

Toby S. Edelman has represented older people in long-term care facilities since 1977. As a Senior Policy Attorney with the Center for Medicare Advocacy since January 2000, Ms. Edelman provides training, research, policy analysis, consultation, and litigation support relating to nursing homes and other long-term care facilities. Ms. Edelman has a J.D. from the Georgetown University Law Center and is a member of the Washington, D.C. Bar.

SAVE THE DATE



This 2-day [Conference](#) will feature 2 tracks — introductory & advanced — focused on bringing Fair Debt Collection Practices lawsuits. Faculty will be drawn from top consumer rights litigators from around the country. For further details and to register, visit <https://www.nclc.org/conferences-training/fair-debt-collection-practices-conference.html>

Buying and Selling Nursing Homes: Who's Looking Out for the Residents?

In recent months, the buying and selling of nursing facilities and the transfers of licenses to new managers have raised questions about who the new owners/managers/lessees are and whether there are sufficient state and federal laws, regulations, and practices in place, meaningfully implemented and enforced, to protect residents.

The issue came vividly into public consciousness when Skyline/Cottonwood, a New Jersey-based company, imploded. Since 2015, Skyline had assumed management of more than 100 nursing facilities in between six and eight states, primarily facilities owned by the nursing home chain Golden Living. Between late March and late April 2018, Skyline/Cottonwood, which had stopped paying many of its workers and vendors, collapsed. The states sought court-approved receiverships or otherwise took over the facilities in order to assure that residents would continue to receive food and medicine and care.[1]

The Philadelphia Inquirer describes the issue with Skyline in stark terms: “The nursing home industry in recent years has been engulfed in wholesale changes in operators as Golden Living and other large companies, often under regulatory and financial pressures, abandon the business and lease bunches of facilities over to firms that emerge from nowhere.”[2]

Some sales of nursing facilities involve purchasers with poor records. Avante, a Florida-based nursing home chain, announced the sale of all six of its North Carolina nursing facilities[3] to SentosaCare, New York’s largest for-profit nursing home company. SentosaCare was the subject of an investigative article in *ProPublica* in 2015 that found that the company had a record of poor care in New York, with 11 of the 25 facilities “exceed[ing] the state average of 24 violations over the past three years,” and three of the facilities having double that number of deficiencies.[4]

In some sales, ownership of nursing facilities is being transferred to real estate investment trusts. Genesis announced plans to sell 23 of its 24 Texas nursing facilities to Regency REIT, LLC by July 1, 2018.[5] HCR ManorCare was forced into bankruptcy and bought by its landlord Quality Care Properties, which, in turn, sold the company to ProMedica and Welltower, a real estate investment trust.[6]

Problems of questionable ownership and management are not new. In May 2015, Utah-based Deseret Health Group (founded in 2006) abruptly stopped paying for food, medical supplies, and workers’ wages and benefits at various nursing facilities it owned, leading several states to pursue court receiverships or otherwise take control of the facilities and protect residents.[7] Twenty years earlier, the founder of Deseret Health Group had been involved in similar problems at other chains of nursing facilities he owned – poor care for residents, bankruptcy, and abrupt closings of facilities.[8] After checking into rehabilitation for a cocaine addiction and also serving time in prison,[9] Robertson was able to start a new company – Deseret – and get licenses in multiple states.

Skyline/Cottonwood collapsed. Private equity firms and other owners are selling nursing facilities or transferring their operating licenses to companies with poor records. Owners with a seriously troubled history are able to start a new company and repeat the history. These practices raise questions about how states and the Federal Government are assuring that residents are protected when facilities, licenses, and management responsibilities are bought and sold or otherwise transferred.

Specifically, what processes do states use to review applicants for nursing home licenses? How do they assure that new managers are qualified and competent to receive licenses to operate the facilities? Are states simply rubber-stamping the new managers that the owners choose? Do state laws set adequate criteria for licensure to fulfill states' police power duty of protecting public health and safety?[10] Do states adequately implement the authority they have?[11]

Similar questions are raised about the federal role. How is the Federal Government assuring that new managers are qualified and competent to receive certification to participate in the Medicare and Medicaid programs? Are federal tools sufficient? Does the Federal Government effectively implement the authority it has?

As nursing home owners buy and sell facilities or transfer management responsibilities to others and as owners with poor records continue to accumulate additional facilities, who is protecting the residents?

May 23, 2018 – T. Edelman

[1] See, for example, Kelsey Ryan and Andy Marso, "How a small company above a N.J. pizza parlor put Kansas nursing home residents at risk," *Kansas City Star* (Apr. 16, 2018), <http://www.kansascity.com/news/business/health-care/article208521454.html>; Harold Brubaker, "Pa. ousts Skyline Healthcare from nine Pa. nursing homes," *Philadelphia Inquirer* (May 2, 2018), at <http://www.philly.com/philly/business/skyline-healthcare-ousted-nine-pa-department-health-nursing-homes-20180502.html>; Maggie Flynn, "Skyline Healthcare Collapsing in South Dakota, Could Dissolve Soon," *Skilled Nursing News* (May 1, 2018), <https://skillednursingnews.com/2018/05/skyline-healthcare-collapsing-south-dakota-dissolve-soon/>.

[2] Harold Brubaker, "Questions about Willow Terrace owner after nursing home collapses in Nebraska and Kansas," *The Philadelphia Inquirer* (Apr. 15, 2018), <http://www.philly.com/philly/business/questions-about-skyline-healthcare-after-nursing-home-collapse-in-nebraska-and-kansas-20180412.html>.

[3] Richard Craver, "Avante plans to sell six NC nursing homes, including three in Triad," *Winston-Salem Journal* (Apr. 18, 2018), http://www.journalnow.com/news/local/avante-plans-to-sell-six-n-c-nursing-homes-including/article_08c98302-148a-5796-8153-0b301a79d1ba.html.

[4] Allegra Abramo and Jennifer Lehman, "How N.Y.'s Biggest For-profit Nursing Home Group Flourishes Despite a Record of Patient Harm," *ProPublica* (Oct. 27, 2015), <http://www.propublica.org/article/new-york-for-profit-nursing-home-group-flourishes-despite-patient-harm#comments>.

[5] "Genesis HealthCare Announces Planned Divestiture of Facilities in Texas" (Apr. 11, 2018), <https://www.nasdaq.com/press-release/genesis-healthcare-announces-planned-divestiture-of-facilities-in-texas-20180411-01214>.

[6] Kimberly Marselas, "HCR ManorCare, about to be sold to Quality Care Properties, is folded into second deal with ProMedica, Welltower," *McKnight's Long-Term Care News* (Apr. 26, 2018), <https://www.mcknights.com/news/hcr-manorcare-about-to-be-sold-to-quality-care-properties-is-folded-into-second-deal-with-promedica-welltower/article/761194/>.

[7] H.B. Lawson, "Nursing home faces closure; Deseret Health Group closing facilities in several states,

Saratoga facility put on chopping block Friday,” *The Saratoga Sun* (May 6, 2015), <http://www.saratogasun.com/story/2015/05/06/news/nursing-home-faces-closure/3898.html>.

[8] Eric Slater, “Entrepreneur Fades From View as Empire Collapses; Business: Critics say owner of shuttered nursing homes, including one in Reseda, lived lavishly amid unpaid bills,” *Los Angeles Times* (Oct. 23, 1997), <http://articles.latimes.com/1997/oct/23/news/mn-45876>.

[9] The Associated Press, “Utah company facing bankruptcy; nursing home residents in limbo,” *KSL* (May 12, 2015). at <https://www.ksl.com/?sid=34610109&nid=148>.

[10] *California Association of Health Facilities v. Department of Health Services*, 16 Cal.4th 284, 940 P.2d 323, 65 Cal.Rptr.2d 872, 885 (1997) (describing the police power as the oversight of public health and safety; describing the purpose of nursing home health and safety regulations as “preventing injury from occurring.”)

[11] The California State Auditor’s recent report finds the Department of Public Health’s licensing decisions reflect “poor defined process and inadequate documentation.” California State Auditor, *Skilled Nursing Facilities: Absent Effective State Oversight, Substandard Quality of Care Has Continued*, Report 2017-19 (May 2018), <https://www.auditor.ca.gov/pdfs/reports/2017-109.pdf>; Linda Stansberry, “State Audit Confirms Inadequacies in For-Profit Skilled Nursing,” *North Coast Journal* (May 1, 2018), at <https://www.northcoastjournal.com/NewsBlog/archives/2018/05/01/state-audit-confirms-shady-doings-by-skilled-nursing-provider>.

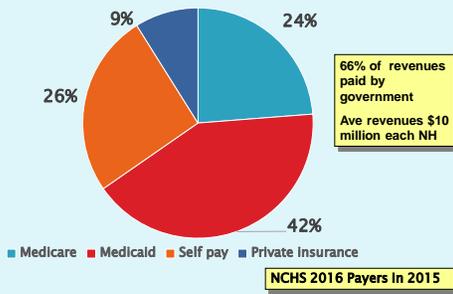
<http://www.medicareadvocacy.org/buying-and-selling-nursing-homes-whos-looking-out-for-the-residents/>~~the~~ [medicareadvocacy.org/buying-and-selling-nursing-homes-whos-looking-out-for-the-residents](http://www.medicareadvocacy.org/buying-and-selling-nursing-homes-whos-looking-out-for-the-residents)

Nursing Home Financial & Accountability Issues

Charlene Harrington, Ph.D. Professor
University of California San Francisco
charlene.Harrington@ucsf.edu
415-269-4080



Who Pays for Nursing Home Care – \$192 Billion 2020



Myth: SNF payment rates are not high enough for good care

Medicare Payment Advisory Commission

Medicare rates are adequate for good care
Recommended no SNF increases 2018 & 2019

CMS announced

\$850 million increase in rates in 2018

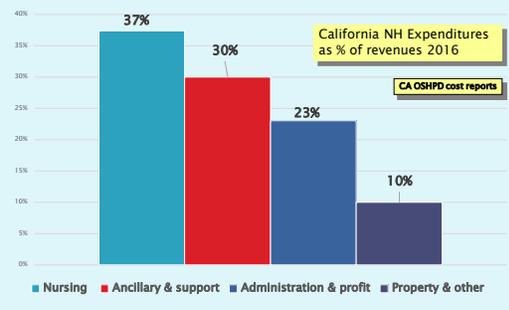
\$2 billion in savings over next 10 years

For-profit nursing homes will reap windfall from tax reform law - (\$140,000 in savings for every \$1 million in revenue)

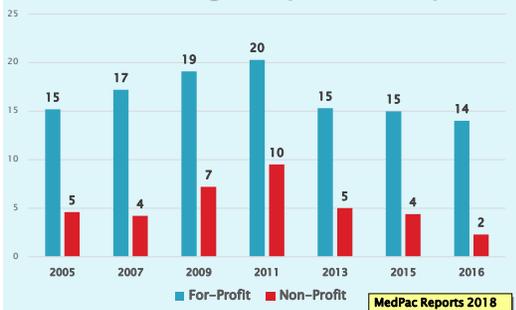
Lack of Accountability with Medicare NH Prospective Payment

- ▶ Medicare prospective payment system pays higher rates based on self-reported resident acuity
- ▶ Encourages false inflation of acuity
- ▶ Audits of acuity and cost reports are not conducted by CMS
- ▶ SNFs are allowed
 - to cut staffing levels and labor costs
 - shift money from care to profits

Where Does the NH Money Go?



Percent Medicare Nursing Home Profit Margins By Ownership

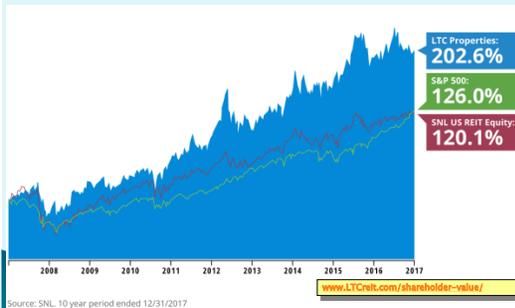


Nursing Home Hidden Profits

- › Leases to related party property companies
- › Management company payments to related party owners
- › Inflated payments to pharmacy, staffing, therapy, and other related party companies
- › Interest rates on loans to owners
- › Owner direct withdrawals
- › Artificial reductions in taxes
- › Related party transactions increased 66% in 3 yrs to over \$1 billion annually in CA

Harrington, Ross, Kang. 2015 Hidden Owners, Hidden Profits. UHS. CA auditor. 2018

Nursing home profits come from real estate investments



Minimum Medical Loss Ratio

- › MLR is the share of revenues spent on patient care as opposed to administration and profits
- › Adopted for health plans in the ACA and saved billions
- › Could adopt for nursing homes by requiring 80% of revenues be spent on nursing care and services (limit administration & profits to 20%)
- › Recoup excess administrative expenses and profits

<http://kff.org/medicaid/report/improving-the-financial-accountability-of-nursing-facilities/>

**There is a clear need for greater
nursing home financial
accountability and limits on
administrative costs and profits**

Financial and Accountability Issues

Increases in nursing home spending continue to be high.

In 2018, nursing homes are expected to receive about \$175 billion dollars, a 3.9 percent growth rate over the previous year. Spending is expected to increase to \$192 billion in 2020.¹ Nursing home spending represents over 5 percent of total personal expenditures in the US.

Who pays for nursing home care?

Medicare paid for 24%, Medicaid and other government pays 42%, private plans pays 9%, and out of pocket is 26% of total expenditures.² For 15,600 nursing homes (1.4 million residents at any point in time), the average nursing home received about \$10 million per facility annually.³

Myth: Payment rates are not enough for good care.

Medicare Payment Advisory Commission reports that Medicare payments to SNFs are too high and finds Medicare rates are adequate to provide good quality of care.⁴ They found that many nursing homes were able to keep their costs relatively low while maintaining relatively high quality. They recommended no market basket increases in Medicare rates for 2018 and 2019.⁴

CMS continues to increase reimbursement rates for nursing homes.

CMS announced that nursing homes will receive an \$850 million increase in reimbursement this year, plus an estimated \$2 billion in savings over the next 10 years under the Patient-Driven Payment Model (PDPM) announced by CMS in April 2018.⁵ For-profit nursing homes will also reap a windfall from the tax reform law – reportedly \$140,000 in savings for every \$1 million in revenue.

Lack of financial accountability with Medicare SNF prospective payment

Congress established the Medicare prospective payment system for SNFs in 1997. The system pays higher rates based on the nursing home self-reported acuity of residents which encourages nursing home to inflate their resident acuity.⁴

Medicare does not conduct audits of casemix or financial cost report data. Because there are no specific minimum staffing requirements, nursing homes are allowed to cut staffing levels and labor costs and shift money from care to profits.⁶

Where does the nursing home money go?

Only about 37 percent of nursing home revenues are spent on staffing and 30 percent are spent on ancillary services (e.g. therapy) and support services (e.g. food, housekeeping). Of total revenues 23 percent goes for administration and profits and 10 percent for property and other costs, using cost report data from California nursing homes.⁷

Nursing homes profits are very high.

In 2016, Medicare SNF profit margins were 11.4% and 25% of nursing homes had over 20% Medicare profit margins. Overall Medicare profit margins averaged over 10% for the past 17 years.⁴ MedPAC has

repeatedly urged Congress to cut SNF reimbursement rates, citing high Medicare margins and concerns over therapy services.

The nursing home industry estimates that Medicaid only pays 89% of actual costs but MedPac shows a positive profit margin overall of about 1%.⁴ The NH financial reports do not show the hidden profits taken by owners.

Profit-taking in the nursing home industry is hidden in related-party transactions that siphon money from care and staffing.

Hidden profits include those taken on leases to property companies owned separately by nursing home owners.⁸ Nursing homes often pay inflated administrative payments to management, pharmacy, staffing and therapy, and other companies owned separately by the owners. Nursing homes sometimes pay excessive interest rates on loans made to the owners. At any time, owners can take direct withdrawals from nursing home funds to pay themselves.⁸

A recent investigation by the California state auditor found related party transactions increased 66 percent over past three years and exceed \$1 billion annually.⁹

Nursing homes make money on their real estate holdings.

For example, a REIT – LTC Properties - recently announced a 203 percent profit over the past 10 years (4.3% compounded interest annually).¹⁰

A minimum medical loss ratio could be adopted for nursing homes.

A medical loss ratio is the share of revenues spent on patient care as opposed to administration and profits. The MLR was adopted for health plans in the Affordable Care Act of 2010 that has saved billions of dollars by requiring health plans to return excess revenues to payers.¹¹ Congress could adopt a requirement that 80 percent of revenues must be paid for nursing care and services and limit the share that can be spent on administration and profits, and can recoup excess administration and profit expenditures.

Policy options

- Congress could set minimum staffing standards to prevent NHs from shifting funds from care to profits.
- Detailed financial reporting should be required for related party companies on administrative costs and profits.
- Greater financial accountability should be established for Medicare nursing homes and audit should be conducted.
- A medical loss ratio should be imposed on nursing homes to limit administrative costs and profits.

References

1. Cuckler GA, Sisko AM, Poisal JA, Keehan SP, Smith SD, Madison AJ, Wolfe CJ, Hardesty JC. (2018). National health expenditure projections, 2017-26: Despite uncertainty, fundamentals primarily drive spending growth. *Health Aff (Millwood)*. 2018 Mar;37(3):482-492. doi: 10.1377/hlthaff.2017.1655. Epub 2018 Feb 14
2. National Center for Health Statistics. (2016) Health United States 2016. Personal health care expenditures, by source of funds and type of expenditure: United States, selected years 1960–2015. <https://www.cdc.gov/nchs/data/hus/2016/095.pdf>
3. Harrington, C., Carrillo, H., Garfield, R., Musumeci, M., and Squires, E. (2018). *Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2009 Through 2016*. The Kaiser Commission on Medicaid and the Uninsured. April. <http://files.kff.org/attachment/REPORT-Nursing-Facilities-Staffing-Residents-and-Facility-Deficiencies-2009-2016>
4. Medicare Payment Advisory Commission. (2018). Report to Congress: Medicare Payment Policy. Chapter 8. March, 205-231. http://www.medpac.gov/docs/default-source/reports/mar18_medpac_entirereport_sec.pdf?sfvrsn=0
5. Centers for Medicare & Medicaid Services (2018). Medicare proposes fiscal year 2019 payment & policy changes for skilled nursing facilities. 2018-04-27. Press release. <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-04-27-4.html>
6. Harrington, C., Wiener, J.M., Ross, L. and Musumeci, M. (2017). *Key issues in long-term services and supports*. The Kaiser Commission on Medicaid and the Uninsured. October 2017. <http://files.kff.org/attachment/Issue-Brief-Key1-Issues-in-Long-Term-Services-and-Supports-Quality>
7. California Office of Statewide Health Planning and Development Office (2015). LTC facilities annual financial pivot profile. <https://www.oshpd.ca.gov/HID/LTC-Financial.asp#Profile>
8. Harrington, C, Ross, L. and Kang, T. (2015). Hidden ownership, hidden profits, and poor quality of nursing home care: A case study. *International Journal of Health Services*. 45 (4): 779-800.
9. California State Auditor (2018). Skilled nursing facilities: Absent effective oversight, substandard quality of care has continued. #2017-109. Sacramento, CA: May. <https://www.auditor.ca.gov/reports/2017-109/summary.html>
10. LTC Reit. (2018). Delivering shareholder value. <http://www.ltreit.com/shareholder-value/>
11. Harrington, C., Ross, L., Mukamel, D., and Rosenau, P. (2013). *Improving the financial accountability of nursing facilities*. Report prepared for the Kaiser Commission on Medicaid and the Uninsured, Washington, DC: Kaiser Commission on Medicaid and the Uninsured, June. <http://kff.org/medicaid/report/improving-the-financial-accountability-of-nursing-facilities/>



POLICY RECOMMENDATIONS: WHAT CONGRESS CAN DO

Robyn Grant
Director of Public Policy and Advocacy
National Consumer Voice for Quality Long-Term Care
rgrant@theconsumervoice.org; 202-332-2275, ext. 205

#1 Protect regulatory standards

68688 Federal Register / Vol. 81, No. 192 / Tuesday, October 4, 2016 / Rules and Regulations DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers for Medicare & Medicaid Services 42 CFR Parts 405, 431, 447, 482, 483, 485, 488, and 489 [CMS-3260-F] RIN 0938-AR61 Medicare and Medicaid Programs; Reform of Requirements for Long Term Care Facilities AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS. ACTION: Final rule.

Ask HHS Secretary Azar and CMS Administrator Verma to retain the federal nursing home regulations as issued in October 2016



#2 Strengthen – not weaken – enforcement

Ask CMS Administrator Verma to:

- **Reverse:**
 - 1) The moratorium on the complete enforcement of 8 vital nursing home regulations
 - 2) The decision to set per-instance, rather than per-day, civil money penalties (CMPs) as the default financial remedy for violations
- **Strengthen** enforcement by ending the persistent under-identification of resident harm



#3 Require financial stewardship – accountability and responsible use of public monies

Pass legislation requiring:

- \$ Greater financial accountability and audits in Medicare nursing homes
- \$ Detailed financial reporting for related party companies on administrative costs and profits
- \$ A medical loss ratio on nursing homes to limit administrative costs and profits



#4 Ensure owners/managers are competent/financially sound

Recent Headline News

Skyline payroll issues force Kansas to seek its largest-ever nursing home takeover

Thousands of nursing home patients nationwide affected by NJ company's financial trouble

Pass legislation requiring:

- Development and state enforcement of procedures that assess purchasers before a transfer of ownership and management occurs, including their:
 - Financial capacity to operate the facilities
 - Compliance & quality of care history



#5 Set minimum staffing standards

Pass legislation requiring:

- Minimum safe staffing for Medicare and/or Medicaid-funded nursing facilities





Connect with us:

www.theconsumervoice.org



Thank You!

Policy Recommendations to Protect Nursing Home Residents

#1 Protect regulatory standards

Issue: Current federal nursing home regulations were revised and released in 2016. They contain important new provisions that better promote quality of care, quality of life, and resident rights. These include improved protections against abuse, neglect and exploitation; enhanced staff training; stronger safeguards against evictions; and required infection prevention. CMS has indicated it will issue a proposed rule in June 2018 to reform these already revised and improved nursing home regulations in order to reduce the burden on providers.

What Members of Congress Can Do: Contact HHS Secretary Azar and CMS Administrator Verma and tell them to retain the regulations as issued in October 2016.

#2 Strengthen – not weaken – enforcement of nursing home regulations

Issue: CMS has weakened the current enforcement system in two ways. First, CMS has reversed existing policy regarding the use of civil monetary penalties (CMPs). This includes making per instance CMPs now the default for financial penalties rather than per day CMPs, which will result in lower and less frequent fines.¹ The threat of fines is a critical deterrent to abuse and substandard care, particularly when they are large enough to impact a facility's actions. Second, CMS has postponed for 18 months any significant enforcement of 8 key regulations that became effective in November 2017. This delay could mean that enforcement may not be sufficient to correct problems and that full implementation of essential provisions may not be achieved until there is real and meaningful enforcement.

What Members of Congress Can Do: Contact HHS Secretary Azar and CMS Administrator Verma and request that CMS reverse: 1) the moratorium on the complete enforcement of the 8 vital nursing home regulations; and 2) the decision to set per-instance, rather than per-day, CMPs as the default financial remedy for violations.

Issue: Each violation of a nursing home regulation is rated according to the harm it causes residents and the number of residents impacted. Approximately 97% of violations are considered “no harm,” which discounts the pain and suffering experienced by residents. Violations that are at the no harm level usually do not trigger serious penalties, such as fines. Consequently, problems such as substandard care continue year after year in many facilities.

What Members of Congress Can Do: Contact CMS Administrator Verma and urge CMS to strengthen enforcement by ending the persistent under-identification of resident harm in nursing homes.

#3 Require financial stewardship – accountability for and responsible use of public monies

Issue: Congress established the Medicare prospective payment system for skilled nursing facilities (SNFs) in 1997. This system pays higher rates based on the acuity of residents – information that is reported by nursing homes themselves. Such an approach encourages nursing homes to inflate their resident acuity. Medicare does not conduct audits of case mix or financial cost report data. In addition, because there are no specific minimum staffing requirements, nursing homes are allowed to cut staffing levels and labor costs and shift money from care to profits.

¹ Per day CMPs start on the first day noncompliance is determined and continue until the facility is back in substantial compliance. Per instance fines are a set amount that is assessed for the noncompliance in general and do not depend on the start and stop date of noncompliance.

What Members of Congress Can Do: Pass legislation requiring greater financial accountability and audits in Medicare nursing homes.

Issue: Profit-taking in the nursing home industry is hidden in related-party transactions that siphon money from care and staffing. Hidden profits include those taken on leases to property companies owned separately by nursing home owners. Nursing homes often pay inflated administrative payments to management, pharmacy, staffing, therapy, and other companies owned separately by the owners.²

What Members of Congress Can Do: Pass legislation that requires detailed financial reporting for related party companies on administrative costs and profits.

Issue: There is no limit to how much nursing homes can spend on administrative costs, how much profit they can make, or how little they can spend on care.

What Members of Congress Can Do: Pass legislation to impose a medical loss ratio on nursing homes to limit administrative costs and profits.

#4 Ensure owners/managers are competent and financially sound

Issue: Sell-off of nursing homes and management responsibility is widespread. A New Jersey company that had acquired the right to manage facilities owned by Golden Living recently became insolvent, leaving at least four states to put multiple facilities under receivership and scramble to find new operators.

What Members of Congress Can Do: Pass legislation requiring CMS to develop, and states to enforce, procedures that assess purchasers before a transfer of ownership and management occurs, including their financial capacity to operate the facilities, as well as their compliance and quality of care history.

#5 Set minimum staffing standards

Issue: There is no required minimum staffing standard for nursing homes. Medicaid and/or Medicare certified facilities must have “sufficient staff” to meet residents’ needs, but this provision is vague and ambiguous. The lack of specificity means that the decision about staffing levels is up to individual nursing homes. Facilities often cut staffing to maximize profits. Lack of enough staff can harm residents and prevent them from getting even the most basic care they need. Understaffing has been linked to pressure ulcers, malnutrition, dehydration, preventable hospitalizations and death.

What Members of Congress Can Do: Pass legislation mandating minimum safe staffing for Medicare and/or Medicaid-funded nursing facilities.

For more information on these issues, please visit www.theconsumervoice.org

The National Consumer Voice for Quality Long-Term Care

1001 Connecticut Avenue, NW, Suite 632

Washington, DC 20036

202.332.2275 (phone); info@theconsumervoice.org (e-mail)

² Harrington, Ross, Kang. 2015 Hidden Owners, Hidden Profits. IJHS.