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April 9, 2019

The Honorable Chuck Grassley
United States Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
219 Dirksen Senate Office Building
Washington, DC 20510

Re: AHCA's response to Questions for the Record (QFR)

Chairman Grassley and Ranking Member Wyden

On behalf of the American Health Care Association (AHCA) and its members, I would like to thank you for the opportunity to provide additional information and answer your additional questions for the record in follow up to the March 6, 2019 hearing: "Not Forgotten: Protecting Americans From Abuse and Neglect in Nursing Homes."

AHCA is the nation's largest association of long term and post-acute care providers representing nearly 10,000 of the 15,000+ nursing homes in the country who routinely provide high quality care to over a million residents and patients every day. We represent nearly half of all not-for-profit facilities, two-thirds of proprietary skilled nursing facilities (nursing homes), and half of government facilities. Our mission is improving lives by delivering solutions for quality care.

I have attached AHCA's response to your questions using the format requested with our answers in red text following each question from each member. If you or any of the committee members should have any additional questions, we are happy to provide more information or meet in person.

Respectively Submitted,

David R. Gifford. MD. MPH
Senior Vice President for Quality and Regulatory Affairs

United States Senate Committee on Finance
"Not Forgotten: Protecting Americans From Abuse and Neglect in Nursing Homes"
MARCH 6, 2019

Questions For the Record
Response by David Gifford, MD, MPH
Senior Vice President of Quality and Regulatory Affairs
American Health Care Association (AHCA)

Chairman Grassley:

A decade ago, the Inspector General performed fingerprint checks on all the workers at 260 nursing homes, and these checks revealed that 92% of the facilities had hired at least one employee with a criminal conviction. A year later, in 2010, Congress authorized up to $160 million for a nationwide background check program to evaluate nursing home employees. But only about half the states have opted to participate in this voluntary program, and an even smaller number contribute enough data for it to be meaningful. Tell us more about the background checks on which your members currently rely to vet prospective hires at nursing homes:

1. **What percentage of nursing homes use fingerprint-based background checks?**

   This number is not readily available on a national level. Although the federal regulations do not explicitly require fingerprint-based background checks, according to CMS guidance, facilities must be thorough in their investigations of the histories of prospective staff. In addition to an inquiry of the state nurse aide registry or licensing authorities, the facility should check information from previous and/or current employers and make reasonable efforts to uncover information about any past criminal prosecutions.

   CMS regulations require that nursing homes not employ or otherwise engage individuals who: (1) have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (2) have had a finding entered into the state nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (3) have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.

   Under the Patient Protection and Affordable Care Act Section 6201, 25 states participate in the National Background Check Program as of 2016. In exchange for funding, these states are supposed to require nursing homes to conduct three types of background checks:

1. *Search of state-based abuse and neglect registries and databases (e.g., nurse aide registries),*
2. *Check of state criminal history records, and*
3. *Fingerprint-based check of FBI criminal history records.*

As you note, to date the National Background Check Program has not resulted in a comprehensive new data source for providers to conduct more effective background checks. Although participating states are supposed to require nursing homes to conduct fingerprint-based checks of FBI criminal history records, the most recent Office of Inspector General (OIG) report indicates that participating states have achieved varying levels of implementation (OEI—07-10-00420).

Moreover, focusing on fingerprint-based background checks will not adequately address concerns about hiring bad actors. The FBI background check produces criminal history records; it will not flag people who have adverse findings (e.g., from a licensing board or civil judgments) where there are no criminal convictions or local or state criminal records. Much of the abuse in nursing homes happens from staff without a state or federal criminal record, but they may have other types of records that could be red flags of potential problems. It is also not feasible for nursing homes to individually query all 50 state nurse aide registries, licensing boards, and state civil judgment data bases. That represents more than 150 unique searches that would need to be conducted prior to each staff hire, with an application fee often required for each database.

Therefore, we recommend access to the National Practitioner Data Bank (NPDB) maintained by HRSA. The NPDB contains information from all 50 states in a single database. It also contains additional information from hospitals and other providers who have terminated a health professional on staff for abuse. The information is submitted from:

- *All state licensure and certification boards*
- *Hospitals that have terminated a provider for abuse*
- *State and federal law enforcement agencies on health care-related civil judgments*
- *State and federal law enforcement agencies on health care-related criminal convictions*
- *OIG exclusions.*

This access would be a significant step toward helping long term care providers more effectively and efficiently screen potential employees for histories of disciplinary problems from all 50 state licensing boards and any prior terminations for abuse. In the testimony by the daughter of Ms. Virginia Olthoff, she indicated that the three nurses involved in her mother's neglect moved to an adjacent state to seek employment in long term care. If nursing homes had

access to the NPDB, it is unlikely they would be able to find employment in another state.

2. **What percentage of your members rely on other types of checks? Please explain.**

   Per CMS Medicare and Medicaid regulations, all nursing homes are required to undertake a thorough background check investigation. A thorough investigation requires a variety of checks. State licensure laws typically specify various checks in addition to a fingerprint-based checks, such as for: state criminal history, sex offender and other abuse registries, and nurse aide registries. Many of our members go beyond the CMS requirements by conducting monthly checks of the OIG List of Excluded Individuals and Entities, checking state police records from surrounding states, repeating the background check for existing employees at specified time intervals (e.g., two years), and conducting drug screening.

3. **Do you think that all nursing home employees should undergo nationwide, fingerprint-based background checks?**

   AHCA does not support this approach for several reasons. First, the relevant information can be more efficiently and effectively obtained through the NPDB. One check of the NPDB would yield nearly all the information that would be found through an FBI fingerprint background check, as well as substantially more information. HRSA reports that the NPDB includes federal and state health care-related civil judgments and criminal convictions, as well state licensing board adverse findings. In contrast, the FBI search will not include civil judgments or information from state licensing boards and registries, only federal or state criminal convictions.

   Second, fingerprint checks are expensive which creates a barrier to hiring staff, when they can get jobs in other health care settings without needing a fingerprint check. The fee for searching the NPDB is $2 per query. In contrast requesting an FBI background check is at least $18. State fingerprint checks and other databases often have a fee as well. Although some providers cover the cost of fingerprint checks, not all do so, and they must shift the cost to the prospective employee who may not be able to afford the search.

   Third, fingerprinting through the FBI can take substantial time both for the prospective hire to travel to an approved location to obtain fingerprints during limited business hours and for the results of the query to return. Nursing homes report waiting weeks for results from the FBI, which is a hardship during this severe workforce shortage. Often employees accept positions at other providers such as hospitals that don't require FBI fingerprint checks. A 2015 Government Accountability Office report details challenges with FBI criminal history record

checks for individuals working with vulnerable populations, including delays and gaps in the information provided (GAO-15-162).

AHCA does support robust screening of applicants. We believe a fingerprint-based approach is costlier and less efficient than using the NPDB, which is why we recommend allowing nursing homes easier access to this resource.

Senator Lankford:

You mentioned that you believe more regulations will not stop bad actors from committing bad actions, and that we need to treat the root causes of abuse cases. As we have learned, the root cause is, in many cases, the bad actors themselves, not the nursing home facility.

1. **Instead of encouraging more government regulations, what do you believe will deter bad actors from entering the industry?**
   We agree that there is often no regulation or penalty that will deter a bad actor from acting out. One reason is that regulations and penalties are typically focused on punishment rather than prevention.

   Most of the current regulations focus on actions or penalties to be taken after the abuse has occurred, which helps with identifying and prosecuting the perpetrator but does not do much to prevent abuse from occurring.

   A process is needed to prevent bad actors from being hired in the first place. Background checks currently in place will reveal if the new employee has a federal or state criminal history. Much of the abuse in nursing homes happens from staff without a state or federal criminal record, but with other types of records that could be red flags of potential problems. It is also not feasible for nursing homes to individually query all 50 nurse aide registries, licensing boards, and state civil judgment databases. That represents more than 150 unique searches that would need to be conducted prior to each staff hire, with an application fee often required for each database.

   Therefore, we recommend access to the National Practitioner Data Bank (NPDB) maintained by HRSA. The NPDB contains information from all 50 states in a single database. It also contains additional information from hospitals and other providers who have terminated a health professional on staff for abuse. The information is submitted from:

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This access would be a significant step toward helping long term care providers more effectively and efficiently screen potential employees for histories of disciplinary problems from all 50 state licensing boards and any prior terminations for abuse. In the testimony by the daughter of Ms. Virginia Olthoff, she indicated that the three nurses involved in her mother's neglect moved to an adjacent state to seek employment in long term care. If nursing homes had access to the NPDB, it is unlikely they would be able to find employment in another state.

2. **How can the industry improve their selection process?**

The selection process and screening of employee applicants is not the problem. CMS has robust regulations already in place for screening new employees and many nursing homes exceed those requirements.

A loan forgiveness program for health care workers electing to work in nursing homes will help attract more qualified applicants to the profession. New nursing school graduates often have large student loan debt and seek employment from hospitals who have the ability to pay higher wages than nursing homes. In addition, hospitals are not subject to the same CMS regulations, reporting and penalties as nursing homes. The enforcement and reporting of abuse and neglect and penalties needs to be the same in all settings (e.g. hospitals, home health, etc) otherwise the government creates a system that makes it difficult for providers with different, more stringent abuse and neglect reporting and enforcement regulations to recruit needed healthcare professionals.

In addition, the current screening process is inefficient, as information is siloed by state and even within states, to multiple databases. This makes it hard for providers to search all the state databases. Therefore, we recommend creating greater access to the HRSA National Practitioner Data Bank to help better detect new hires who have a history of federal or state crimes related to health care and histories of termination from staff of hospitals or other health care settings.

Senator Young:

Electronic Staff Training

In some of your testimonies, you bring up the issue of staff training. With the advancement of technology, many nursing homes these days offer staff training electronically.

1. **What processes are in place to verify staff skills/competency? How frequent are skills tested?**

   CMS regulations in the Long-Term Care Facility Requirements of Participation (RoP) require nursing homes to take what is referred to as a competency-based approach to staffing. Nursing homes are required to have staff with the competencies and skill sets to assure resident safety and attain or maintain the highest practicable well-being of each resident as determined by their resident assessments and person-centered plans of care. In addition to the competencies of licensed nursing staff, nurse aides must demonstrate competency in skills and techniques needed to care for residents' assessed needs as included in their care plans.

   "Competency" is defined as a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully. Nursing homes delineate competencies required for nursing staff and assess and evaluate staff competency using a variety of approaches, including lectures with return demonstration, pre- and post-tests, competency fairs, interactive scenarios or role plays, checklists, peer reviews, self-assessment, observations, and examinations.

   Through an annual facility-wide assessment, nursing homes are required to have processes in place to assess the needs of their resident population given factors such as their physical disabilities and overall acuity and determine the competencies to provide the care their residents need. This facility assessment is documented and updated annually as well as whenever there is a major change in the resident population such as the addition of a ventilator or bariatric unit. If a nursing home identifies any new competency needs or gaps through this annual assessment, they are required to provide training and verification of these new competencies for all relevant staff.

   Nurse aides must complete a training and competency evaluation program or a competency evaluation program approved by the state in order to work in a nursing center. Nurse aides are evaluated for competencies including communication and interpersonal skills, resident rights, mental health and social service needs, and care of cognitively impaired residents. Nurse aides are

required to receive in-service training to ensure their continuing competence and must receive no less than 12 hours of in-service training per year, though typically much more. The required in-service training includes dementia management training and resident abuse prevention training. Nursing homes are also required to update their required nurse aide training when they identify areas of weakness in nurse aides' performance reviews and the annual facility-wide assessment. If a nurse aide has not worked as a nurse aide for 24 consecutive months, they must be retrained before working again in a facility.

CMS also requires nursing homes to develop, implement, and maintain an effective training program for all new and existing staff as well as contract staff and some volunteers. The contents and curriculum of this training program are linked to the annual facility-wide assessment. Required training topics include effective communication for direct care staff; resident rights and facility responsibilities; abuse, neglect, and exploitation; quality assurance and performance improvement; infection control; compliance and ethics; and behavioral health. Facilities must make ongoing revisions to their training program whenever there are changes to the resident population, staff turnover, changes to the physical environment, or other major modifications. They use a variety of training methods, including in-person instruction, webinars and/or supervised practical training hours, and curricula include performance standards and evaluation criteria, as well as methods for tracking staff completion of required training.

2. **After initial certification and licensing tests, how often are skills actually reviewed by nursing home leadership to determine proficiency?**

   Skills and competencies are reviewed and evaluated at least annually and more frequently as needs arise due to changes in the nursing home's population, when there are major staffing changes, through at least annual updates to the facility-wide assessment, through nurse aide performance reviews, and through the implementation of the facility's required training program. Nurse aides receive a minimum of 12 hours of in-service training to enable nursing home leadership to evaluate and ensure their continuing competence each year, though training typically far exceeds this minimum amount. Staff competencies and proficiencies are also continually evaluated on the job through skills fairs, return demonstration of direct care skills, classroom hours, and supervised practical training.

Senator Wyden:

Nursing Home Staffing: Numerous academic research and CMS studies have demonstrated that direct care nursing staff is the key to good quality of care. Specifically, a past CMS report identified thresholds for nursing staffing levels that result in fewer quality of care problems. Yet, an analysis of CMS's January 2019 data by my staff showed that almost half of nursing homes nationwide were understaffed by RNs and over 60% were understaffed by CNAs. Further, when the level of RNs and CNAs was below CMS's suggested thresholds, we found that the severity of the deficiencies cited on inspection increased—meaning that more often state survey agencies found instances of actual harm or of residents' being in immediate jeopardy.

1. **What is the relationship between staffing levels and quality of care?**

   There is a large body of literature demonstrating a correlation between staffing levels and quality of care in nursing homes. The research generally indicates that average higher staffing is more likely to be associated with higher quality. However, the research does not show that higher staffing always results in better quality, nor does lower staffing always result in lower quality. An analysis of CMS Five-Star ratings shows that 8.2% of facilities received excellent or deficiency-free surveys and yet, those same facilities are reported as having low staffing levels. Conversely, 15.6% of facilities with high staffing (four or five stars) had received one or two stars on survey inspections.

   The research literature also shows that turnover and retention of staff are equally, if not more important, that staffing levels. CMS could use the new Payroll-Based Journal (PBJ) data to measure staff turnover and retention, which would help improve quality. AHCA has supported focusing on turnover and retention, making it a centerpiece of its Quality Initiative. Without CMS support by including turnover and retention as a measure in PBJ, it has made it difficult to increase the focus on these issues.

   As stated in our written testimony, hiring staff is a significant challenge facing nursing homes across the country and particularly in rural areas. A loan forgiveness program for health care workers electing to work in nursing homes would help with staffing levels. In addition, as Dr. Grabowski testified, much of this is related to Medicaid reimbursement policies and made worse in facilities with high Medicaid census, particularly in rural areas. MedPAC's analysis has shown that Medicaid pays far less than the actual cost of care. We agree with Dr. Grabowski's and MedPAC's research findings. To help address nursing home staffing, Congress and CMS needs to develop a program to help facilities with high Medicaid census and examine Medicaid rates.

2. **How can Congress and/or CMS take action to ensure that nursing facilities have a level of overall staffing that will ensure quality care to their residents?**

As Dr. Grabowski testified, one of the strongest predictors of staffing levels is the Medicaid census. There are many academic studies, some by Dr. Grabowski, that show a strong relationship between Medicaid payments, staffing and quality as well as the relationship between the number of Medicaid recipients in a nursing home and quality.

Labor costs are a significant operational expense for a nursing home. The majority of revenue in a typical nursing home is from two government-funded programs: Medicare and Medicaid. The reimbursement rates are set by the federal government for Medicare and state governments for Medicaid. To increase staffing, a facility must incur greater operational expenses, which would require them to raise rates for the care provided. It is not possible to raise rates for patients whose care is funded by Medicare and Medicaid. As the census of Medicaid beneficiaries increases, this puts greater stress on a facility, particularly rural facilities, which can lead to closure. The recent New York Times article about rural nursing home closures[1] and Dr. Grabowski's testimony illustrated this effect.

As such, nursing homes with large proportions of residents being covered by Medicaid need to have some type of additional payment. Prior evaluation by CMS has shown that a staffing increase will cost billions of dollars. AHCA recently used the new staffing data collected by CMS and the wage index information published by CMS and the Department of Labor to calculate the cost to hire more staff at levels commonly advocated for by consumer advocates. This analysis found that increasing staffing would cost approximately $5-6 billion dollars a year depending on how much of the increase is devoted to nurses (RNs and LPNs) or Certified Nursing Assistants (CNAs).

[1] New York Times: Nursing homes are closing Across Rural America, Scattering Residents. March 4, 2019. https://www.nytimes.com/2019/03/04/us/rural-nursing-homes-closure.html

CMS Support for Recommendations Made In Report *Sheltering In Danger.* Prior to the hearing, you and your colleagues from the American Health Care Association met with my staff to discuss emergency preparedness at nursing homes. During that meeting, you indicated that AHCA supported many of the recommendations in my report, *Sheltering in Danger*. The report has 18 recommendations for government, the nursing home industry and other stakeholders.

1. **Review each recommendation, and indicate, individually (e.g. A-1, A-2, B-1, B-2, etc.), whether or not AHCA supports the recommendation.**

   AHCA supports the intent behind all the recommendations and appreciates your efforts. Some recommendations, as currently worded, are not feasible without modifications. Our comments related to each recommendation are listed in the next question. We are also happy to meet with you or your team to discuss our comments and how to ensure that these recommendations are implemented in a manner that achieves the desired outcomes.

2. **For recommendations that AHCA does not support in full, please explain why.**

   A-1: AHCA supports with modifications. AHCA would like to clarify if a standard heath index is being proposed that would apply to all facilities or if a provider would be responsible for making daily calculations. OSHA makes recommendations on incorporating heat indexes into consideration for workers specific to those working outdoors. Heat indexes will affect air temperatures differently indoors and outdoors, making it difficult to measure and monitor without complex equipment. Also, there would be value in defining the difference between comfortable versus safe temperatures during emergencies. Otherwise, you may be evacuating frail elderly for temperatures and heat indexes that are outside comfortable range but within a safe range for emergency situations. As you know, evacuating residents has its own risks and has been shown to increase morbidity and mortality.

   A-2: AHCA supports with modifications. AHCA would like clarification if the proposed reissue of the Emergency Preparedness rule or interpretive guidance to include the safe and comfortable temperature standard is the temperature range defined in 42 CFR Part 483.10(i)(6). This temperature range is for normal operations and may be different for an emergency event. There would be value in defining the difference between comfortable versus safe temperatures. Guidelines should make this distinction and allow providers to focus on maintaining safe levels during an emergency. Otherwise, you may be evacuating frail elderly for temperatures and heat index that are outside comfortable range but within safe range for emergency situations.

   A-3: AHCA supports the concept that we need to better clarify and evaluate the role of emergency power availability to maintain safe temperature. Without knowing the specific details CMS may propose, it is hard to take a firm position. AHCA believes the emergency preparedness rule is adequate to pursue maintenance of safe and comfortable temperatures but agree that there remains confusion on how it is applied and enforced. If additional requirements are pursued, AHCA strongly recommends phasing in any changes and establishing enough time for providers to plan and budget for additional equipment. As has

been shown in a number of emergencies, onsite or available equipment is not always the problem, nor does it ensure safe temperature and operations after an emergency. The logistics and local ordinances for equipment take a significant amount of time and resources to install. It is critical that the government offer funding to assist with the financial burden with any changes to this regulation.

A-4: AHCA supports this recommendation. Existing NFPA regulations require proper use of equipment according to manufacturer recommendations. The recently updated interpretive guidance for the emergency preparedness rule, Appendix Z, also requires following manufacturer requirements.

A-5: AHCA supports this recommendation to provide additional guidance on planning and preparing for heat emergencies.

A-6: AHCA supports this recommendation of coordinating with electricity providers to ensure that higher priority is given to nursing homes.

B-1: AHCA supports this recommendation to clarify roles and responsibilities of who can order, respond and mandate shelter-in-place and evacuation orders.

B-2: AHCA supports this recommendation for more research and developing best practices for making sheltering-in-place and evacuation decisions.

C-1: AHCA supports with modifications. AHCA would like to clarify if the process for reviewing and approving long-term care facilities' emergency plans would be different than the current nursing home survey process. If the process is different, it is important to know which agency would approve such plans. Currently, the surveyor's area of expertise for the emergency preparedness regulation varies by state. Our members have shared that that they experience inconsistency during surveyor(s) interviews on the subject. AHCA would recommend that CMS provide guidance on the type of surveyor (e.g., life safety specialist) who is to review compliance with these requirements. Surveyors must be knowledgeable and well-trained in emergency preparedness to review plans and evaluate compliance. Review and approval of the plans would require significant training, additional resources and time dedicated to properly review. State and local governments may not have the resources to do so. The recommendation also includes that CMS and states should ensure emergency managers have proper training and qualifications. It is also important to clarify whether the emergency manager is working for the state or as part of nursing home staff.

C-2: AHCA supports this recommendation to better integrate nursing home and assisted living providers into community-wide emergency planning strategies. AHCA believes health care coalitions can support these efforts and would also consider the pending OIG report on "Examining Healthcare Coalitions'

Partnerships With Non-Hospital-Based Facilities in Community Preparedness Efforts."

C-3: AHCA supports with modifications. AHCA would like clarification on the decision-maker referred to in this recommendation. AHCA would recommend CMS to provide recommendations or best practices facilities can use in their plan on making and reassessing such decisions.

C-4: AHCA supports this recommendation. The current emergency preparedness rule askes providers to detail this information as part of their communication plans and subsistence needs for staff and residents, whether they evacuate or shelter-in-place.

C-5: AHCA supports this recommendation with modifications. Emergency plans should include transportation contracts to ensure safe and timely evacuations. However, all events are different and can lead to various competition for resources making individual contracts difficult to maintain. Many nursing homes have experienced the state or local official commandeering transportation and other resources during a large-scale emergency. This underscores the need for working with the local and state emergency agency. AHCA would recommend state or local governments offer assistance or take responsibility in securing and prioritization of emergency transportation contracts.

C-6: AHCA supports this recommendation with modifications. Key medical personnel should have an active role in the emergency planning process. For example, it may not be feasible to have the Medical Director present for an emergency., It is common practice for a medical director to serve multiple facilities. Without modifications, this recommendation would restrict physicians to work as medical director in only one facility.

C-7: AHCA supports this recommendation. Through the existing regulation, providers in coastal areas are required to identify their risks through a documented, facility- and community-based risk assessment utilizing an all-hazards approach. There is a potential opportunity to provide training and resources to help monitor flood zones.

D-1: AHCA supports this recommendation to coordinate communication with state and local authorities. AHCA encourages members to communicate through their state or local emergency operations center during an event. State and local authorities should provide clear and consistent guidance and procedures for centers regarding emergency communications that the center will incorporate into their plan. This could potentially be a simple flow chart of communication of who providers need to call, what information to provide and when to provide it.

D-2: AHCA supports this recommendation for communication plans to include designated points of contact during an emergency. Providers can use the Incident Command System to help with effective communication. AHCA would like clarification on the training mentioned in the recommendation, including the specific goals and vision for the training. This could be an opportunity for state and local authorities to provide training and guides that includes the identified points of contact to review procedures and protocols.

E-1: AHCA supports this recommendation for state and local officials and power providers to re-examine power restoration priority protocols for at-risk populations.

Senator Cardin:

Screening Process for Employees: Families with a loved one requiring complex medical care must sometimes make the decision to place their loved one in a nursing home for long-term care. This can often be an emotional decision, but it can be helped along by finding a nursing facility and staff that will provide high quality care. Many times families who entrust a nursing facility and its employees with the care of their loved one have great experiences.

However, today we have heard several harrowing stories of families seeing their loved ones heinously mistreated and assaulted at the nursing homes where they were residents. Most disturbing, is that the assailants were in positions of trust because they were in charge of the residents' care.

1. **Is there a screening policy when hiring new employees to nursing facilities? Or does such screening vary state to state, facility to facility?**

   Yes, all nursing homes are required to screen potential new employees and to have policies and procedures for screening. CMS Medicare and Medicaid regulations require that nursing homes not employ or otherwise engage individuals who: (1) have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (2) have had a finding entered into the state nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (3) have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.

   Nursing homes must be thorough in their investigations of the histories of prospective staff according to CMS guidance. In addition to an inquiry of the state nurse aide registry or licensing authorities, the nursing home should check

information from previous and/or current employers and make reasonable efforts to uncover information about any past criminal prosecutions.

State licensure laws typically specify various types of checks in addition to a fingerprint-based check, such as for: state criminal history, sex offender and other abuse registries, and nurse aide registries. Many of our members go beyond the requirements by conducting monthly checks of the OIG List of Excluded Individuals and Entities, checking state police records from surrounding states, repeating the background check for existing employees at specified time intervals (e.g., two years), and conducting drug screening.

2. **Is there something the federal government could do, whether is it legislation or regulation, which would help in the screening of applicants for positions at nursing homes?**

   AHCA recommends access to the National Practitioner Data Bank (NPDB) maintained by HRSA. The NPDB contains information from all 50 states in a single data bank. The information is submitted from:
   - *All state licensure and certification boards*
   - *Hospitals that have terminated a provider for abuse*
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3. **Do nursing facilities conduct training programs for staff to recognize signs of abuse or violence? Could you describe what these training programs entail and how often they are conducted?**

   Yes, nursing centers are required by CMS to provide staff orientation and ongoing training on the prohibition of all forms of abuse, neglect, and exploitation. The training must, at a minimum, educate staff on activities that constitute abuse, neglect, exploitation, and misappropriation of resident property; procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property; and dementia management and resident abuse prevention.

Further, CMS guidance details the training elements that centers must include in staff orientation and in ongoing training, focusing on both identifying and preventing abuse. These training programs address how person-centered care practices contribute to a facility culture of prevention and identification of abuse, neglect, and exploitation; identifying and preventing behavior constituting abuse; identifying physical or psychosocial indicators of abuse including verbal, mental, sexual or physical abuse; taking or using photographs or recordings of residents in a demeaning or humiliating manner and sharing them in any manner, including through the use of technology or social media; and more.

In addition to these topics, training also includes facility procedures and federal and state requirements for reporting abuse; timeframes and other requirements for reporting; reporting reasonable suspicion of a crime against a resident; factors related to dementia care and abuse prevention; conflict resolution and anger management skills; and identifying and addressing factors that may precipitate abuse/neglect/exploitation, including signs of frustration or stress or prejudicial attitudes.

Focus on Prevention: We have heard a lot today about the regulations and enforcement actions CMS has in place to address elder abuse and neglect. For example, there is both state and federal law that outline penalties for elder abuse and neglect. In addition, CMS may even apply civil monetary penalties up to $21,393 per day upon a nursing home when cited for abuse or neglect that harms a resident. However, these steps are taken after the neglect or abuse has occurred.

I am interested in developing strategies to prevent the abuse and neglect from happening in the first place. This is where I see the federal government having a role to be a partner with nursing facilities and state health departments.

1. **What steps could be taken by the federal government, state agencies, and nursing facilities to prevent abuse and neglect from happening in nursing homes?**

   Prevention efforts can be thought of in two ways: first, how to prevent something from happening (primary prevention) versus how to prevent something from getting worse (secondary or tertiary prevention). Both are effective strategies but should be done in concert since neither alone is effective in preventing something from happening.

   Currently, most CMS regulations and enforcement actions to address abuse would be classified as secondary or tertiary prevention efforts (that is steps and actions taken after an allegation of neglect or abuse). There is less focus on steps to prevent instances of abuse, or primary prevention.

It is AHCA's position that neither the number of regulations nor the amount of penalties imposed (both secondary and tertiary prevention efforts) will stop bad actors from engaging in bad activities. Rather, we would recommend focusing on primary prevention strategies to prevent neglect or abuse before it happens. To identify potential causes of abuse and neglect to develop primary prevention recommendations, we have spoken with members and considered the abuse and neglect citations issued by CMS. A common theme arises related to not hiring individuals who are likely to cause abuse or neglect. The screening process currently has some gaps that can allow staff with a history of abuse or neglect moving to another state to seek employment, as we heard in the testimony from Virginia Olthoff's daughter. This is why we are recommending greater and easier access to the National Practitioner Data Bank maintained by HRSA.

The NPDB contains information from all 50 states in a single data base. It also contains additional information from hospitals and other providers who have terminated a health professional on staff for abuse. The information is submitted from:

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- *State and federal law enforcement agencies on health-care related criminal convictions*
- *OIG exclusions.*

This access would be a significant step toward helping long term care providers more effectively and efficiently screen potential employees for histories of disciplinary problems from all 50 state licensing boards and any prior terminations for abuse. In the testimony by the daughter of Ms. Virginia Olthoff, she indicated that the three nurses involved in her mother's neglect moved to an adjacent state to seek employment in long term care. If nursing homes had access to the NPDB, it is very unlikely they would be able to find employment in another state.

Second, we need to be able to hire more and better staff, but we often lose qualified staff to hospitals and other provider settings that pay higher wages. New graduates from nursing, pharmacy, therapy and social work schools often have large student loan debts. When nursing homes are able to identify or train high quality staff, staff often take jobs in hospitals or resign from a nursing home to accept positions in a hospital. Nursing homes are in desperate need of a program to attract and retain more nurses, aides, and health professionals, such as social workers and activities coordinators. AHCA recommends a loan

forgiveness program for health care workers who select working in nursing homes to help with staff recruitment.

Telehealth to Improve Care in Nursing Homes Follow-Up: I wish to follow up on the questions I raised during the hearing regarding telehealth as a way to reduce unnecessary hospitalizations. I asked whether there is an issue understanding telehealth, a lack of its availability, whether there is a lack of staffing, or a regulatory issue preventing the use of telehealth from being more prevalent. Dr. Gifford, you mentioned that one of the issues surrounds reimbursement. You also mentioned there are a number of different ways to solve the problem generally, but because of time, you could not fully discuss the possible solutions.

1. **Can you elaborate not only on the reimbursement issue, but also on other potential solutions to improve and expand the use of telehealth as a way to reduce unnecessary hospitalizations?**

   Under Medicare, telehealth services have proven to be a beneficial treatment option for millions of Americans in their home and in facilities. Specifically, telehealth services offer broader patient access to address emergent and some ongoing health care needs in situations where a physician is unavailable to render face-to-face care. With appropriate telehealth technology, remotely located physicians can assess and order treatment interventions that could stabilize or resolve a health issue, avoiding the disruption and costs associated with a preventable hospital admission.

   Section 149 of the MIPPA (P.L. 110-275) added skilled nursing facilities as telehealth originating sites effective for services on or after January 1, 2009. However, CMS has promulgated regulations that have severely limited the potential benefit of telehealth services to nursing home residents. Although Congress, through MIPAA and the IMPACT Act of 2014, seeks to standardize quality measurement across settings to facilitate innovative care delivery models, CMS continues to impose setting-specific regulatory barriers to achieving these results.

   Since the introduction of telehealth coverage under the Medicare benefit in calendar year 2010[i], beneficiary access to telehealth services for skilled nursing facility residents has been severely restricted by CMS regulations. Notably, regulations at 42 CFR 414.65, CMS placed a "… limitation of one telehealth visit every 30 days by the patient's admitting physician …", while the limitation is only once every three days for inpatient hospitals and other post-acute care provider settings, including Inpatient Rehabilitation Facilities and Long-Term Care Hospitals. This restriction on telehealth access to skilled nursing facility residents is a barrier to aligning post-acute care delivery and the success of several physician and skilled nursing facility value-based payment (VBP) initiatives,

including the recently implemented SNF VBP program that seeks to reduce avoidable hospital readmissions.

*Aligning the physician telehealth frequency limitations across PAC settings, particularly in rural and underserved locations, would provide the physician and the skilled nursing facility another valuable tool to evaluate a patient's status and make clinical decisions that could reduce the risk of negative health outcomes. We note that a majority of skilled nursing facility patients, particularly long-stay residents, present with multiple chronic conditions. As recently as August 12, 2016, in a Report to Congress, the Secretary of Health and Human Services stated that, "Telehealth appears to hold particular promise for chronic disease management…Ensuring ready access to care for such individuals may help avert costly emergency room visits or hospital stays**[ii]**."*

An equally notable and important regulatory barrier to the effective use of telemedicine to avoid hospitalizations involves the restriction to underserved geographical areas. Most skilled nursing facility residents are in facilities that do not qualify, even though the need and opportunity is enormous, particularly during nights and weekends.

We ask the committee to contact CMS and put all post-acute care settings on a level playing field. Aligning the physician telehealth frequency limitations across post-acute care settings, particularly in rural and underserved locations, would provide the physician and the skilled nursing facility another valuable tool to evaluate a patient's status and make clinical decisions that could reduce the risk of negative health outcomes.

[i] 74 FR 61761, November 25, 2009.
[ii] Department of Health and Human Services, Office of Health Policy, Office of the Assistant Secretary for Planning and Evaluation (ASPE). Report to Congress: E-Health and Telemedicine. August 12, 2006.

Senator Brown:

Improving Access to Medicare Coverage: Just a few weeks ago I worked with my colleagues Sen. Collins, Sen. Whitehouse, and Sen. Capito to reintroduce bipartisan legislation to update a current loophole in Medicare policy that would help protect seniors from high medical costs for the skilled nursing facility care thy require after hospitalization. My *Improving Access to Medicare Coverage Act* would allow for the time patients spend in the hospital under "observation status" to count toward the requisite three-day hospital stay for coverage of skilled nursing care.

1. **Dr. Gifford: can you please explain the importance of this legislative fix, as it relates to the patient population you serve?**

   This bipartisan legislative fix you and your colleagues introduced would greatly help patients across the country from being surprised by costly medical bills and is endorsed by AHCA/NCAL. Additionally, 33 national organizations strongly support your bill. Increasingly, patients have no idea what their status is in a hospital, or the importance of it, which can lead to thousands of dollars in out-of-pocket medical expenses should they need skilled nursing center care following their hospital stay. In addition to placing a financial burden on seniors and their families, this anomaly in Medicare rules can cause unnecessary spend-down, accelerating the time frame in which seniors will have to turn to programs such as Medicaid to pay for their care.

   As you know, for Medicare to cover a post-hospital stay in a skilled nursing facility (SNF), the patient must have spent at least three days as a hospital inpatient. This is known as the "SNF Three-Day Rule," and is part of the Medicare statute. Because observation is an outpatient designation, days in observation would not satisfy the SNF three-day rule, even if skilled nursing care is deemed medically necessary. As more and more patients are placed under observation rather than admitted as an inpatient, they face barriers to accessing their Medicare skilled nursing facility benefit, including being denied admission to a skilled nursing facility or being required to pay out-of-pocket for skilled nursing care costs. AHCA/NCAL believes that because there is virtually no difference between the medical care provided to observation patients and inpatients, days spent under observation should count as inpatient days for the purposes of satisfying the SNF three-day rule.

   While we strongly support your legislation that would allow observation days to count as inpatient for purposes of satisfying the SNF 3-day rule, we also believe that CMS could provide a solution administratively. CMS has the legal authority to define what is considered "inpatient" for purposes of satisfying the SNF 3-day rule. "Inpatient" is defined neither in statute nor in regulation; it is defined in the Medicare Benefit Policy Manual. CMS has made determinations in other areas of the Medicare program to allow non-Part-A-covered days in a hospital count as inpatient in order to satisfy the SNF three-day rule:

   - *In the context of hospice services, CMS has recognized that "general inpatient care" in a hospital, although "not equivalent to a hospital level of care under the Medicare hospital benefit," nevertheless qualifies a hospice beneficiary for Part A-covered skilled nursing care facility services; and*
   - *A three-day stay in a foreign hospital may qualify a beneficiary for Part A skilled nursing facility coverage if the foreign hospital is qualified as an "emergency hospital."*

AHCA/NCAL believes CMS could modify the Medicare Benefit Policy Manual to allow days a patient spends under "observation" in a hospital to count as "inpatient" in order to satisfy the SNF three-day rule.

Binding Arbitration. In 2016, the Obama Administration issued a rule to update the health and safety standards that long-term care facilities must meet to participate in Medicare and Medicaid. One of the things this rule did was ban pre-dispute arbitration agreements, or binding arbitration clauses, meaning the Obama Administration prohibited nursing homes from requiring residents to sign arbitration agreements as a condition of care. During the hearing, Senator Wyden raised the issue of pre-dispute arbitration agreements. I share his concern over this issue.

1. **Dr. Gifford: is it true that after the Obama Administration issued this rule, the American Health Care Association sued to get a preliminary injunction to block the rule from taking place by utilizing the court system?**

   Yes, HHS and CMS violated the Federal Arbitration Act and exceeded their statutory authority by banning pre-dispute arbitration agreements in nursing facilities in the Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities; Final Rule (Oct. 4, 2016). AHCA successfully sought relief in AHCA v. Burwell (Northern District of Mississippi, Oxford Division). Judge Michael P. Mills granted AHCA's motion for a preliminary injunction and issued an order preventing the rule from taking effect. The government dismissed its appeal.

Cuts to Medicaid. The Trump Administration's most recent budget proposal would cut the Medicaid program by more than $4 trillion over the next decade. One out of every three nursing home residents relies on Medicaid to cover the cost of their care.

1. **Dr. Gifford: in your professional opinion, would significant cuts to Medicaid exaggerate the challenges nursing homes – and especially rural nursing homes – face in providing access to quality care?**

   Medicaid is the primary payer for long term services and supports (LTSS), many of which are not covered by Medicare or private insurance. The program plays an especially important role for older adults, especially as they age, with 37 percent of older adults ages 65-74 requiring LTSS and that number increasing to 74 percent at age 85 or above.[1] On average, Medicaid pays for 62 percent of the patients in nursing centers on any given day in 2018.[2] However, the projected percentage of nursing center revenue from Medicaid during this same period is about 29 percent.[3] Margins are thin under the program's existing financing structure. Dramatic cuts that, depending on state policy decision, result in drastic cuts to nursing center rates, would not be sustainable. Data show that not only

are older adults a growing part of the population as a whole, but rural areas have a higher share of adults who are ages 65 and older.[4] People in rural areas face many challenges access care, including finding certified caregivers.[5]

Academic publications by Dr. Grabowski, which he summarized in his testimony, clearly demonstrate a relationship between the Medicaid rates and census in a facility and the quality of care. In his testimony, Dr. Grabowski acknowledged that the rural closures reported in a recent New York Times article were due to Medicaid payment rates and policies. We have found similar findings in analyses looking at the Medicaid census in a facility. For example, an increase in the Medicaid patient population by 1% decreased the odds of having an overall CMS Five-Star rating greater than or equal to three by 22.6%. This same analysis shows that large, for-profit, rural, chain-membership facilities on average take care of more Medicaid patients than others. MedPAC has also shown that Medicaid commonly pays far less than the cost of providing care. Any cuts to the Medicaid program will likely cause quality to get worse and the closure of nursing homes that care for large population of Medicaid beneficiaries, particularly in rural areas.

[1] http://files.kff.org/attachment/Infographic-Medicaids-Role-for-Seniors
[2] AHCA analysis of CASPER data 2018Q4.
[3] National Health Expenditure Projections 2018 to 2027.
[4] https://www.pewsocialtrends.org/2018/05/22/demographic-and-economic-trends-in-urban-suburban-and-rural-communities/
[5] http://www.rupri.org/wp-content/uploads/LTSS-RUPRI-Health-Panel-2017.pdf

2. **Dr. Gifford: would significant cuts to the Medicaid program through block grants or a per capita cap exaggerate the closure of more rural facilities?**

Medicaid is the only source of LTSS funding for the vast majority of older adults. Virtually all individuals with developmental disabilities, 62 percent of nursing center patients rely on Medicaid on a given day for their care. The private long-term care insurance marketplace largely has stopped issuing new policies and, for those people with policies in force, the premiums have become unaffordable. In the absence of an adequately funded Medicaid program and/or an affordable private alternative, states and the federal government would face a crisis under a capped system regarding meeting the LTSS needs of a growing population of older adults, especially those over age 85, as well as increasing numbers of people under age 65 who require LTSS.

Since policies that would cap federal Medicaid funding have typically been based on historical, point-in-time spending data, this is especially problematic for the older adult (65 years and up) population because of aging trends and new disability trends among older adults. Rates of disability vary widely across the country among older adults.[1] While future trends are difficult to predict,[2],[3]

research suggests a rising number of older adults age 80 and older who typically need long-term care, as well as what appears to be a reversal in recent declines in disability among older adults. Such trends collectively will result in an increase in disability among people age 65 and older. Dramatic changes to federal financing of the program which, depending on state policy decision and the impact on state budgets, result in drastic cuts to nursing center rates, would not be sustainable. As Dr. Grabowski testified, such cuts would likely make quality worse, lower staffing levels and result in more closures of nursing homes, particularly those with a large Medicaid census.

[1] https://www.census.gov/newsroom/press-releases/2014/cb14-218.html
[2] He, W. and Larsen, L. Older Americans With a Disability: 2008–2012 American Community Survey Reports. U.S. Department of Health and Human Services, National Institutes of Health, National Institute on Aging; U.S. Department of Commerce, Economics and Statistics Administration, U.S. Census Bureau. December 2014 and accessed here.
[3] Lin, S., DrPH, Beck, A., PhD. Trends in US Older Adult Disability: Exploring Age, Period, and Cohort Effects. American Public Health Association. October 2012. Available here.

3. **Dr. Gifford: in addition to protecting the integrity of the Medicaid program, you mentioned during the hearing during an exchange with Senator Daines that federal legislators could consider the integration of Medicare to help support individuals in long-term care. Can you please elaborate on what you meant?**

The exchange between Dr. Grabowski and Senator Daines referenced integrated products of Medicaid and Medicare, specifically special needs plans (SNPs) under Medicare Advantage. There have been a number of efforts to better integrate care for people dually enrolled in the Medicare and Medicaid programs over the past several years, as Dr. Grabowski referenced in his testimony. Skilled nursing centers have a unique opportunity, because they work with many dual eligible in their buildings every day, to possibly enhance the effects of greater integration by allowing Institutional-SNPs (I-SNPs) to manage the Medicaid portion of their population as well. For example, there are I-SNPs run by long term care providers that are managing services for people in their buildings and showing positive health outcomes. This is possible because:

1. *They have the ability to align the actions of all providers involved in a resident/member's care through value-based contracts and quality measurement.*
2. *The I-SNP provides the funding to employ higher level clinical staff such as Nurse Practitioners and Physician's Assistants who can be present in the facility more often than a physician yet also perform some of the same functions as a physician increasing the opportunity to treat in place, reducing potentially avoidable emergency department visits and inpatient stays.*

3. *The I-SNP incents the provider to be proactive, ensuring preventive care is provided and keeping members/residents as healthy as possible.*

Two of the key challenges that will continue to exist in rural areas are:

1. *Adequate volume of people enrolled in I-SNPs so there are sufficient resources to care for a population with significant health care and other needs, and*
2. *Access to clinical providers.*

Skilled nursing facilities already employ the majority of clinical providers in some rural areas. Leveraging the staff and infrastructure already in place and coupling it with integrated Medicare and Medicaid funding through an I-SNP or long-term care-led ACO may be sufficient to overcome the barrier of low enrollment. PACE programs are built on similar principles of combined funding streams managing a small number of nursing facility eligible members and have been successful in producing improved health outcomes and reduced cost.

Staffing Challenges. During the hearing, Senator Hassan asked some important questions around the challenge of adequately staffing nursing homes with qualified individuals. Both the recruiting and retaining of high quality staff were raised as challenges.

1. **Dr. Gifford: in response to Sen. Hassan's questions, you mentioned a program that would increase payments to nursing homes for staffing purposes only. Can you please elaborate on this program and other mechanisms you believe would help to better support the nursing home workforce?**

   To improve the workforce shortage in nursing homes, we need to increase the number of health professionals available to work in nursing homes, improve the retention (and decrease the turnover), and encourage new staffing models that decrease the demand for nursing positions. Training more nurses will take time and there are not enough nursing schools and positions available to train all the nurses needed. Another approach is to look to increasing visas for international nurses and other health care professionals. Many other countries use such an approach to meet the increased demand in long term care services from the Baby Boomer generation reaching 85 years of age.

   We need to increase the number of health professionals who work in nursing homes. Increasing wages is a common refrain, which will help but there are other approaches as well. For example, many nurses today graduate with large student loan debt and seek employment at hospitals. A loan forgiveness program for nurses working in nursing homes would help attract nursing homes and would be less expensive than increasing Medicare and Medicaid rates. As Dr. Grabowski

testified, one of the reasons leading to closure of nursing homes is low Medicaid rates, which commonly pays less than cost but is the dominant payor in most nursing homes. On average, Medicaid covers about two-thirds of residents in a nursing home. If the Medicaid census is low, then other insurance programs including Medicare that reimburse at a higher rate can cover the losses by Medicaid, a practice MedPAC strongly disagrees with. However, as the Medicaid census increases, this cross subsidization is not feasible, which Dr. Grabowski testified is a driving cause of nursing home closure and low staffing. As such, we would propose a program modeled after the Disproportionate Share Hospital (DSH) payments, where nursing homes with high Medicaid census receive an additional payment to cover the losses. There are different ways to construct such a program and we would be happy to meet with you and your staff to discuss these approaches.

Another challenge with increasing staffing is the statutory language that blocks the use of CNA training programs for two years when a facility has a CMP imposed. While we agree that a training program should not occur in a facility with serious quality concerns, a two-year mandatory closure restricts the ability of a facility to not only train new staff but makes it harder to recruit staff. This action has the unintended effect of making it harder for the facility to make and sustain meaningful changes to correct the problem that triggered the citation and CMP by CMS. We would propose legislative change to allow restarting such programs once a facility is back in compliance with federal regulations that triggered the CMPs rather than a two-year moratorium.

LGBTQ Seniors. According to the nonprofit organization Services and Advocacy for Gay, Lesbian, Bisexual, and Transgender Elders (SAGE), there are an estimated 1.5 million gay, lesbian, and bisexual people over 65 currently living in the US, and that number is expected to double by 2030. In 2016, PBS NewsHour did a segment highlighting the discrimination and unique challenges these seniors face as they age and need long-term care services. These challenges have been compounded by recent efforts by the Trump Administration that would lead to further disenfranchisement of the LGBTQ community, including the Department of Health and Human Services (HHS) proposal to reduce data collection about the well-being of, and roll back protections for, LGBTQ individuals across programs.

1. **Dr. Gifford**: data demonstrates that LGBTQ individuals are more likely to rely on long-term and assisted living facilities for care, but will also experience high rates of discrimination from fellow patients, caregivers, and other providers. Harassment and discrimination can lead not just to mental health challenges like depression and suicide, but can also contribute to other negative health outcomes. **Can you please provide the committee with your views on best practices for preventing bias-motivated abuse in nursing facilities, particularly as it relates to the LGBTQ population?**

Best practices to prevent bias-motivated abuse include facility policies and staff training. Facilities should have non-discrimination policies and a facility norms policy that is inclusive of sexual orientation, gender identity, and gender expression. Staff training should include LGBT cultural competencies, abuse prevention and residents' rights. Creating anonymous mechanisms to report abuse can also be helpful.

2. **Dr. Gifford: are you aware of any protections currently in place to prevent bias-motivated abuse? Do you believe that these are sufficient, or would you recommend additional efforts to prevent discrimination and bias-motivated abuse/neglect?**

   Nursing home residents have the rights and protections provided by federal nursing home regulations and state and federal anti-discrimination provisions. Current protections for LGBT Elders are included in the CMS State Operations Manual Appendix PP: Guidance to Surveyors for Long Term Care Facilities. These protections include guidance regarding rights to designate a representative and right of same-sex spouse, rights to roommate choice, and visiting rights. In 2017, the state of California passed the S.B. 219, which established a bill of rights for LGBT elders residing in long term care facilities. In 2018, the state of Massachusetts passed An Act Relative to LGBT Awareness Training for Aging Services Providers. This law requires aging service providers to complete training on the prevention and elimination of discrimination based on sexual orientation, gender identity and expression and on improving access to services for LGBT elders.

Senator Whitehouse:

1. **Are the current reporting requirements for nursing homes clear in terms of providing a proper signal of the quality of care provided at these facilities? If not, what changes to the quality reporting requirements would you recommend to ensure we have clear information about which facilities are providing high-quality care and which need improvement?**

   CMS reports information on all Medicare or Medicaid certified nursing homes. The information is posted on Nursing Home Compare and broken into five categories (health inspections, fire safety inspections; staffing, quality outcomes and penalties). CMS rates facilities on a Five-Star scale for three of these categories (health inspections, staffing, and quality outcomes) which are also combined into an Overall Five-Star rating. This is the most comprehensive set of data and ratinsg available to the public but has been criticized by consumers, providers and academic researchers. In particular, academic researchers have

criticized how CMS combines the information into the overall ratings. CMS weights some areas more than others and that often does not reflect what consumers may want. As a result, the staffing and quality outcomes each only count on average for about 15% of the overall rating. A system that allows the customer to say how important and how much each component should count toward the overall rating would help provide clearer information.

The survey component has been criticized as the variation in how each state enforces the national regulations results in different numbers or citations across the country that don't correlate well with staffing or health outcomes. CMS also assigns stars on a forced distribution curve (e.g. 20% in each state receive 1 star and only 10% can receive five stars) no matter how well or poorly the facilities in the state are doing on the survey inspections. As a result, you have some states with very few survey citations getting one or two stars that in other states would have resulted in three or four stars and vice versa. This does not give the consumer very clear information. Also, as nursing homes get better or worse on complying with the regulations, there is no change in the star rating, which is misleading to the consumer because it may appear that nothing is changing.

The survey inspection results do not specify how many unique residents were related to the citation. Often one resident's care results in multiple citations but in other facilities with similar citations, citations may be each for a different, unique resident. As such, consumers may be left with the impression that two facilities are similar because they have the same number of citations when in fact, one facility received the citations for one resident while the other for multiple residents. Similarly, CMS does not adjust the results for the number of residents in a facility. Data from CMS shows that facilities with more residents, receive more citations compared to facilities with fewer residents. This means that larger facilities will always look worse than smaller facilities not because there is difference in quality or compliance, but because CMS did not adjust for the difference in facility size.

CMS announced significant changes to the reporting requirements effective in late April 2019. Some of these changes help provide better information to consumers, such as breaking the quality outcomes into measures related to short-term rehabilitation that reflect care for approximately four million admissions per year to skilled nursing facilities following a hospital stay so that they can recover and return. Previously, these measures were combined with clinical outcomes for residents who were living in the nursing home long term. As a result, consumers needing clear information to select a skilled nursing facility for post hospital rehabilitation care were basing their decision on measures related to long term care not short-term rehabilitation care.

CMS recently required facilities to report the hours worked by staff in the facility, a program AHCA has supported. However, CMS made two policy decisions that result in information that is not accurate on staffing levels. First, CMS requires the deduction of 30 minutes for every employ who works for eight hours or more a day, for meal and break time. This occurs regardless of whether the person took a break or not. Second, CMS will not count hours for exempt employees (salaried employees) who work for more than 40 hours in a week to count those hours unless they are paid for those hours over 40 hours. CMS is treating these employees as if they are non-exempt. Many nurses are salaried (e.g. exempt employees) who work extra shifts or cover a shift when a nurse calls out sick. However, these hours are not counted. This makes the facilities nursing hours look less than they really are. These two policy decisions cause the staffing hours to not be an accurate reflection of the staffing levels in the facility.

Lastly, one glaring absence in the reporting requirements by CMS is the collection and publication of customer satisfaction. CMS reports customer satisfaction for other providers (such as for hospitals and home health) but not for nursing homes. We would recommend that CMS require the collection and publication customer satisfaction as part of the Five-Star rating system.

Senator Cortez Masto:

In your testimony you advocate for the inclusion of family members' feedback in quality metrics. Ms. Blank described a satisfactory experience with her mother's care up until she passed.

1. **How could we make sure that this feedback doesn't inflate the rating of a nursing home that is providing substandard care?**

   Consumer satisfaction measures are a standard and accepted measure of quality. We believe satisfaction is an important metric that should be part of the portfolio of measures publicly reported. Nursing homes are the only provider type that CMS does not collect and report on satisfaction.

   While there will be examples of inconsistent findings between the measures or an individual patient's experience, that does not invalidate the measure, nor does it inflate a provider's score and ratings. Currently, CMS reports on three types of quality measures: results of the on-site inspection, staffing levels and clinical outcomes and combines the ratings for each into an overall rating. While these three measure types are correlated, they are not perfectly aligned. For example, there are cases where a facility with excellent survey inspections has low staffing and poor outcomes and vice versa. The combining of each measure type

prevents one measure from inflating or deflating the overall rating. Adding customer satisfaction to this portfolio adds additional information not currently available.

We believe adding customer satisfaction will add new and important information for consumers to help guide their choice of facilities and monitor the quality of the facility for their family members who are receiving care there. Data on satisfaction in nursing centers shows a range of high and low satisfaction suggesting it can distinguish between facilities with different resident and families experience with the care and staff.