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ON

“NOT FORGOTTEN: PROTECTING AMERICANS FROM ABUSE AND NEGLECT IN NURSING HOMES”

BEFORE THE
U. S. SENATE FINANCE COMMITTEE

MARCH 6, 2019

Chairman Grassley, Ranking Member Wyden, and Members of the Committee, thank you for the invitation and the opportunity to discuss the Centers for Medicare & Medicaid Services' (CMS's) ongoing efforts to ensure that Americans in nursing homes receive high quality care. For vulnerable Medicare and Medicaid beneficiaries residing in nursing homes for long stays, these institutions are much more than healthcare facilities – they have become homes. Every nursing home serving Medicare and Medicaid beneficiaries is required to keep its residents safe and provide high quality care. We have focused on strengthening requirements for nursing homes, working with states to enforce statutory and regulatory requirements, increasing transparency of nursing home performance, and promoting improved health outcomes for nursing home residents.

Across our efforts, we work to make sure the focus remains where it should be – on the patient and their family. By reducing administrative burden through our Patients Over Paperwork initiative[1], CMS is allowing clinicians to spend more time with their patients, which is particularly important in a nursing home setting where residents have more complex care needs, and care decisions are sometimes directed by family members. Reducing provider burden can also lower administrative costs, allowing facilities to dedicate their resources to other areas such as improving patient care. Our Meaningful Measures framework,[2] launched in 2017, helps make sure providers are held accountable for the quality of care they provide by identifying high priority areas for patient-centered, outcome-based quality measurements in all health care settings. For example, "make care safer by reducing harm caused in the delivery of care" is one of the six Meaningful Measures domains, and includes measures such as avoiding complications like bed sores and preventing healthcare-associated infections.

We appreciate the significant time and effort dedicated to this issue by Chairman Grassley and Ranking Member Wyden, and we look forward to working with this Committee and Congress as we continue to enhance our efforts to improve both the quality of services received and the quality of life experienced by nursing home residents. We also greatly appreciate the work of the

[1] https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/PatientsOverPaperwork.html
[2] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/MMF/General-info-Sub-Page.html

Government Accountability Office (GAO), the Department of Health and Human Services Office of Inspector General (HHS-OIG), and the Department of Justice (DOJ), including their recommendations and ongoing assistance to ensure resident safety and facility compliance.

Strengthening Nursing Home Requirements

Every nursing home resident has the right to be treated with dignity and respect, and we expect every nursing home to meet this expectation. All long-term care facilities that seek to participate in Medicare and Medicaid must comply with basic health and safety requirements set forth in statute[3] and regulation,[4] including requirements for infection control, quality of care, nursing services, the unnecessary use of psychotropic medications, and many others. Compliance with these requirements is determined through unannounced, annual on-site surveys conducted by state survey agencies in each of the 50 states, the District of Columbia, and the U.S. territories. To prevent facilities from being able to predict the occurrence of their next survey, annual surveys are conducted at varying time intervals. The statewide average interval between surveys must be no greater than 12 months, but individual facilities may experience a gap of up to 15 months between annual surveys.[5] Nursing homes must remain in substantial compliance with these requirements, as well as applicable Federal, state, and local laws, and accepted professional standards, to continue as a Medicare or Medicaid participating provider.[6]

In 2015, CMS issued a revised regulatory proposal for public comment based on the findings of a comprehensive review of our existing regulations. This review focused on ways to improve the quality of life, care, and services in long-term care facilities, optimize resident safety, reflect professional standards, and improve the logical flow of the regulations.

This process resulted in CMS issuing – for the first time in over 25 years – a final rule[7] updating the requirements for nursing homes and other long-term care facilities. These revisions are an integral part of our efforts to hold nursing homes accountable for improved health outcomes,

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[3] Sections 1819 and 1919 of the Social Security Act
[4] 42 C.F.R. part 483, subpart B
[5] Sections 1819(g)(2)(A)(iii) and 1919(g)(2)(A)(iii) of the Social Security Act.
[6] 42 C.F.R. §483.70(b)
[7] Available at https://www.federalregister.gov/documents/2016/10/04/2016-23503/medicare-and-medicaid-programs-reform-of-requirements-for-long-term-care-facilities

while at the same time minimizing administrative burden for providers. The changes also reflect the significant innovations in resident care and quality assessment practices that emerged over the previous three decades, as the population of long-term care facilities has become more diverse, more clinically complex, and more has been learned about resident safety, health outcomes, individual choice, and quality assurance and performance improvement.
Of particular note, the final rule made a series of changes that resulted in a more streamlined regulatory process, aligning program requirements with current clinical practice standards to enhance resident safety and improve the quality and effectiveness of care delivered to residents.

Among other provisions, the 2016 rule finalized changes intended to:

- Ensure that facilities provide residents with the necessary care and health services including behavioral health, based on a comprehensive assessment, to attain the highest practicable physical, mental health and psychosocial well-being.
- Require all long-term care facilities to develop, implement, and maintain an effective comprehensive, data-driven quality assurance and performance improvement program that focuses on systems of care, outcomes of care, and quality of life.
- Ensure that long-term care facility staff members are properly trained on resident’s rights, properly caring for residents including caring for residents with dementia, and in preventing elder abuse.
- Ensure that long-term care facilities take into consideration the health of residents when making decisions on the kinds and levels of staffing a facility needs to properly take care of its residents.
- Improve care planning, including discharge planning, for all residents with the involvement of the facility’s interdisciplinary team and consideration of the caregiver’s capacity, which will give residents information they need for follow-up after discharge, and ensure that instructions are transmitted to any receiving facilities or services.
- Expand protections for residents from the use of inappropriate drugs, including expanding requirements for those who use psychotropic drugs or who have not previously used psychotropic drugs, including antipsychotics.

We have since reviewed these changes with a focus on reducing administrative burden while prioritizing resident safety and have begun enforcing and monitoring implementation. In response to public comments and to ensure facilities have time to make these important, long-term changes, CMS is implementing this rule in three phases based on the complexity of the revisions and the work necessary to revise interpretive guidance and survey processes. The schedule for the three phases is:

- Phase 1: Beginning in November 2016, the implemented rules included provisions that did not impose additional requirements on facilities or were straightforward to implement.
- Phase 2: In November 2017, a revised survey system incorporating the new requirements was introduced.
- Phase 3: Starting in November 2019, this phase will include requirements that will take longer for nursing homes to implement, such as such as including a new compliance and ethics program.

A key component of the requirements for participation in the Medicare and Medicaid programs are emergency preparedness standards for the planning, preparing, and staff training for potential emergency situations. CMS issued a final rule[8] in September 2016 updating and improving upon the emergency preparedness requirements for nursing homes and other providers and suppliers participating in Medicare and Medicaid to add additional requirements to safeguard residents and patients during emergency situations. For example, CMS now requires facilities to use an "all-hazards" risk assessment approach in emergency planning to identify and address location-specific hazards and responses.[9] In addition, facilities are now required to develop and maintain an emergency preparedness training and testing program for new and existing staff, along with a communications system to contact appropriate staff, patients' treating physicians, and other necessary persons in a timely manner to ensure continuation of patient care functions.[10]

[8] Available at https://www.gpo.gov/fdsys/pkg/FR-2016-09-16/pdf/2016-21404.pdf
[9] 42 C.F.R. §§483.73(a)(1)
[10] 42 C.F.R. §§483.73(c), (d)

The new emergency preparedness standards became effective on November 15, 2016, and state surveyors began to evaluate compliance with the new requirements as part of the certification and recertification survey process on November 15, 2017. As of February 22, 2019, 98 percent of the 15,581 active nursing homes have been surveyed under the new emergency preparedness requirements, and over 70 percent of these were found to be in compliance. We expect all certified nursing homes to be surveyed for compliance with these new requirements by the end of this month. All facilities that have been cited for noncompliance deficiencies under these requirements have made the necessary corrections to come into compliance with the emergency preparedness requirements.

Earlier this year, we issued clarifying manual interpretative guidance for nursing homes and state survey agencies on emergency preparedness.[11] The instructions included adding emerging infectious disease threats to the current definition of all-hazards approach and clarifying standards for alternate source power and emergency standby systems.

Working with States to Enforce Nursing Home Requirements

Monitoring patient safety and quality of care in nursing homes serving Medicare and Medicaid beneficiaries requires coordinated efforts across the Federal Government and states. In addition to meeting Federal statutory and regulatory requirements, nursing homes must also meet state licensure requirements, which vary by state. Because the state survey agency is usually the same agency responsible for both state licensure and Federal surveys, these on-site surveys are typically performed by the same state team at the same time, with the state and Federal findings identified separately: one for state licensure purposes and one for Medicare and Medicaid compliance purposes. The state survey agencies also manage the intake of complaints and conduct investigations accordingly.

To help ensure greater consistency among state survey agencies, in November 2017, CMS implemented a new computer-based standardized survey methodology across all states. This new resident-centered survey process provides surveyors with more information on quality of care

[11] Available at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO19-06-ALL.pdf

issues at that facility and allows surveyors more flexibility to ensure the quality of care issues and concerns they identify through resident observation and interviews are addressed. CMS makes results of these surveys available through our Nursing Home Compare website[12] and through datasets on our Quality, Certification, and Oversight Reports database[13] and the Medicare data website.[14] In April 2018, CMS began distributing monthly performance feedback reports to CMS Regional Offices and state survey agencies, identifying reporting issues such as inconsistencies with Federal processes. CMS Regional Offices meet quarterly with state survey agencies in their region to discuss survey outcomes and issues, and CMS meets monthly with a panel of state survey agency directors to discuss survey issues.

Addressing Suspected Abuse and Neglect in Nursing Homes

Abuse and mistreatment of nursing home residents is never tolerated by CMS, and the agency takes any allegation of these types of incidents very seriously. CMS requires nursing homes to report allegations of abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, immediately to their state survey agency.[15] When we learn a nursing home failed to report or investigate incidents of abuse, CMS takes immediate action against the nursing home. For example, in 2018, when a state surveyor found that a nursing home did not properly investigate or prevent additional abuse involving 2 residents, placing other residents on the unit at risk for abuse, the nursing home was cited at the most serious level of noncompliance (immediate jeopardy) and assessed a civil monetary penalty of approximately $798,679. In addition to issuing civil monetary penalties, CMS can, and under certain circumstances must, deny payments or terminate a facility's Medicare and Medicaid participation agreements when appropriate.

State survey agencies can conduct complaint surveys at any time, and anyone can file a complaint, including residents, family members, nursing home staff, and anyone else who has reason to suspect abuse or neglect is taking place. CMS's Nursing Home Compare website[16] includes links and other helpful information to help patients and families determine when and

[12] https://www.medicare.gov/nursinghomecompare
[13] https://qcor.cms.gov/main.jsp
[14] https://data.medicare.gov/
[15] 42 C.F.R. §483.12(c)
[16] https://www.medicare.gov/NursingHomeCompare/Resources/State-Websites.html

how to file a complaint. Nursing homes are required to post similar information on how to file complaints and grievances in their facilities.[17]

When state surveyors identify noncompliance with Federal certification requirements, including abuse, they document this for the facility and, in cases where the facility is not in substantial compliance, refer the case to CMS for enforcement. To continue to participate in Medicare and Medicaid, the facility is required to address identified issues and develop a corrective action plan[18]. When immediate jeopardy to resident health and safety exists, meaning that the provider's noncompliance with one or more requirements has caused, or is likely to cause, serious injury, harm, impairment, or death, CMS and the State Medicaid Agency may terminate the facility and/or install temporary management in as few as two calendar days, and up to 23 calendar days,[19] after the survey which determined immediate jeopardy exists. Civil monetary penalties can also be assessed up to approximately $20,000 per day until the immediate jeopardy is removed and substantial compliance is achieved, as well as other remedies. A facility's removal of the conditions that caused the immediate jeopardy may, at CMS's discretion, result in the rescission of the termination if the facility demonstrates substantial compliance with all requirements during an unannounced re-survey.

For deficiencies that do not constitute immediate jeopardy situations, remedies could include directed in-service training, denial of payments, or civil monetary penalties. While CMS has the authority to terminate Medicare participation of all providers (including nursing homes) and suppliers because of noncompliance with the applicable statutory or regulatory requirements, State Medicaid Agencies have the authority to terminate Medicaid providers and suppliers in their state. State Medicaid Agencies are also required to deny or terminate the enrollment of any provider that has been terminated for cause under Medicare or another state's Medicaid or CHIP program, in accordance with relevant regulatory provisions. Nursing facilities that do not achieve substantial compliance within six months are terminated from Medicare and Medicaid participation.

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[17] 42 C.F.R. §483.10
[18] https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c07.pdf
[19] 42 C.F.R. §§488.410, 488.456(c), 489.53(d)(1) and 489.53(d)(2)(ii)

When a provider's certification has been terminated from the Medicare program and we see signs of potential fraud or abuse, CMS may refer this information to the HHS–OIG and potentially the DOJ based on the facts and circumstances surrounding the termination.

Special Focus Facilities

The Special Focus Facility initiative was developed to address those nursing homes that would be identified as providing substandard quality of care, having more problems or more serious problems than other nursing homes, or having a pattern of serious problems that persisted over a long period of time. Often, these nursing homes would institute enough improvements to address the presenting problems in order to come into compliance and continue to receive Medicare payments, but then significant problems would re-surface by the time of the next survey, leading them to be identified as providing substandard quality of care again. Such facilities with a "yo-yo" or "in and out of" compliance history rarely addressed underlying systemic problems that were giving rise to repeated cycles of serious deficiencies. Nursing homes designated as a Special Focus Facility are inspected by survey teams twice as frequently as other nursing homes and must recommend progressively stronger enforcement actions in the event of continued failure to meet the requirements for participation with the Medicare and Medicaid programs. For example, the Regional Office could impose a higher civil money penalty or add a Denial of Payment for New Admissions if consecutive surveys find problems.

The Special Focus Facility program provides a mechanism for state survey agencies and CMS Regional Offices to provide additional attention and resources to these facilities for the purpose of improving their quality of care and protecting residents. CMS has strengthened the Special Focus Facility program over the past several years to ensure that homes either improve so that they can graduate from the program, or they are terminated from Medicare and Medicaid participation. The objective of all enforcement remedies is to incentivize swift and sustained compliance in order to protect resident health and safety. Within 18-24 months after CMS identifies a facility as a Special Focus Facility nursing home, we expect that the facility would make significant, lasting improvements and graduate from this program, be terminated from the Medicare and Medicaid programs, or show promising progress but be permitted to continue as a

Special Focus Facility for some additional time.

Our efforts are designed to help facilities come back into compliance, as well as prevent future noncompliance, without requiring a termination from the Medicare and Medicaid programs that would lead to disruptions in patient care. Nevertheless, our primary obligation is to ensure that all nursing home facilities are safe and can meet resident needs, and we will terminate facilities that do not appropriately correct deficiencies.

Increasing Transparency of Nursing Home Performance

Promoting transparency is a key factor to protecting patient safety and holding facilities accountable for the health outcomes of their residents, and CMS is committed to empowering patients and their families by providing access to the information they need to support their health care decisions for long-term care facilities. Through our Nursing Home Compare website,[20] consumers and families have the ability to compare facilities' performance in key areas. This transparency of performance information also serves as a strong, market-based motivator for facilities to make continuous improvements to the quality of care they provide.

Nursing Home Compare and Nursing Home Five-Star Quality Rating System

CMS first created the Nursing Home Compare website in 1998 and has regularly increased the amount of information available to beneficiaries and their families about the quality of care in nursing homes participating in the Medicare and Medicaid programs. In 2008, we introduced a quality rating system that gives each nursing home a rating of between 1 and 5 stars. CMS's Nursing Home Compare website contains information for more than 15,000 Medicare and Medicaid nursing homes around the country.

CMS bases the ratings of the Nursing Home Five Star Quality Rating System on an algorithm that calculates a composite view of nursing homes from three measures: results from their annual surveys; performance on certain quality measures, such as re-hospitalizations and unplanned emergency visits; and staffing levels. Copies of the detailed annual survey reports, along with results

[20] https://www.medicare.gov/nursinghomecompare

from complaint surveys, are available on the Nursing Home Compare website.

CMS continues to work to improve Nursing Home Compare and the Five Star Quality Rating System. In 2016, CMS expanded the number of quality measures included in Nursing Home Compare and the Five Star Quality Rating System. In April 2018, we took steps to improve the accuracy of the staffing information by using Payroll-Based Journal data, and, most recently, in October 2018, we added new measures on hospitalizations, falls, and care planning for functional ability. The survey information on Nursing Home Compare and the Five Star Quality Rating System is typically updated on a monthly basis, and quality measure and staffing information is typically updated quarterly.

Tracking Nursing Home Staffing Data through the Payroll Based Journal

CMS has long identified staffing as one of the vital components of a nursing home's ability to provide quality care. Current law[21] requires facilities to electronically submit direct care staffing information (including agency and contract staff) based on payroll and other auditable data. In 2015, CMS developed the Payroll-Based Journal system, which allows all facilities to submit their staffing data each quarter. The data, when combined with resident census information, is then used to calculate the level of staff in each nursing home.

This new staffing information is calculated using the number of hours facility staff are paid to work each day in a quarter, instead of the previous method of calculating staffing information using the total number of hours facility staff worked over a two-week period as self-reported by the facility, and submitted about once a year. Importantly, unlike the previous data source, the new data are auditable back to payroll and other verifiable sources.

In April 2018, CMS began using data from this system to post staffing information on the Nursing Home Compare tool. The Payroll-Based Journal data provides unprecedented insight into how facilities are staffed, which can be used to analyze how facilities' staffing relates to quality and outcomes. Already, the new data has helped us identify issues, such as days with no registered nurse reported onsite. We are deeply concerned about these issues and are working to

[21] Section 1128I(g) of the Social Security Act and 42 C.F.R. §483.70(q)

address them. For example, we started in July 2018 to adjust the Nursing Home Compare ratings by assigning a one-star staffing rating to facilities that report seven or more days in a quarter with no registered nurse. Last November, we announced three updates to the Payroll-Based Journal reporting program. CMS will now use frequently-updated payroll-based data to identify and provide state survey agencies with a list of nursing homes that have a significant drop in staffing levels on weekends, or that have several days in a quarter without a registered nurse onsite. State survey agencies are required to conduct surveys on some weekends based on this list. If surveyors identify insufficient nurse staffing levels, the facility will be cited for noncompliance and required to implement a plan of correction. We have also updated the Payroll-Based Journal Policy Manual to provide clarification on how nursing homes should report hours for "universal care workers" and deduct time for staff meal breaks, and providing facilities with new reports to ensure they are submitting data accurately and in a timely manner. In the future, we anticipate using this data to report on employee turnover and tenure, which impacts the quality of care delivered.

Promoting Improving Outcomes and Quality of Care in Nursing Homes

Making sure residents receive high quality care – and making sure we are meaningfully measuring the quality of care they are provided – is critical to our efforts to improve patient safety. Patient harm resulting from inadequate staffing or the prescription of unnecessary medication can be just as serious as harm resulting from abuse or neglect, and we have several initiatives in place to help facilities improve patient outcomes and the quality of care provided.

National Partnership to Improve Dementia Care in Nursing Homes

In 2012, in response to quality and safety concerns related to the use of antipsychotic medications among a growing number of residents with dementia, CMS launched the National Partnership to Improve Dementia Care in Nursing Homes. The Partnership uses a multidimensional approach that includes public reporting, state-based coalitions, research, provider and surveyor training, and revising surveyor guidance to optimize the quality of care for all residents, especially those with dementia, by reducing the use of antipsychotic medications

and enhancing the use of non-pharmacologic approaches and person-centered dementia care practices.

Since the launch of the Partnership, there have been significant reductions in the prevalence of antipsychotic medication use in long-stay nursing home residents. Between the end of 2011 and the end of the second quarter of 2018, the national prevalence of antipsychotic use in long-stay nursing home residents was reduced by 38.9 percent, decreasing from 23.9 percent to 14.6 percent nationwide. The Partnership continues to work with state coalitions and nursing homes to reduce the rate even further. In October 2017, to build on that progress and demonstrate the Partnership's renewed commitment to improving quality of care in nursing homes, CMS encouraged facilities with low rates of antipsychotic medication use to continue their efforts and maintain their success, and set a new goal for those with higher rates to decrease antipsychotic medication use by 15 percent for long-stay residents by the end of 2019.[22] Among these specific facilities, the prevalence of antipsychotic use among long-term residents decreased by 11.7 percent between the end of 2011 and the second quarter of 2018, indicating that we are making significant progress towards meeting this 15 percent goal.[23] We continue to look for opportunities to strengthen both the survey process and enforcement efforts to ensure that nursing homes consider non-pharmacologic approaches when appropriate and that residents are not receiving unnecessary medications.

National Nursing Home Quality Care Collaborative

CMS also leads the National Nursing Home Quality Care Collaborative with the Quality Innovation Network-Quality Improvement Organizations. The Collaborative launched in April 2015 with the mission to improve care for the 1.4 million nursing home residents across the country; currently, over 78 percent of the nation's nursing homes participate. [24]. The Collaborative works to rapidly spread the practices of high performing nursing homes nationwide with the aim of ensuring that nursing home residents receive the highest quality of

[22] https://www.cms.gov/newsroom/fact-sheets/data-show-national-partnership-improve-dementia-care-achieves-goals-reduce-unnecessary-antipsychotic

[23] https://www.nhqualitycampaign.org/files/Late_Adopter_Report.pdf

[24] All Cause Harm Prevention in Nursing Homes Change Package, available at: https://qioprogram.org/sites/default/files/editors/141/C2_Change_Package_20181226_FNL_508.pdf

care. Specifically, the Collaborative strives to instill quality and performance improvement practices, eliminate healthcare-acquired conditions, and dramatically improve resident satisfaction by focusing on the systems that impact quality, such as staffing, operations, communication, leadership, compliance, clinical models, quality of life indicators, and specific, clinical outcomes. For example, CMS and the Quality Innovation Network National Coordinating Center released an All Cause Harm Prevention in Nursing Homes Change Package on November 28, 2018, highlighting the successful practices of high-performing nursing homes. The Change Package covers a wide range of strategies and actions to promote resident safety and describes how the nursing home leaders and direct care staff at chosen sites shared and described their efforts to prevent, detect, and mitigate harm.[25]

Skilled Nursing Facility Quality Reporting Program and Value-Based Purchasing Program

In recent years, we have undertaken a number of initiatives using payment reforms to promote higher quality and more efficient health care for Medicare beneficiaries. Implementing programs like the Skilled Nursing Facility Quality Reporting Program and the Skilled Nursing Facility Value-Based Purchasing Program is an important first step towards transforming Medicare from a passive payer of claims to an active purchaser of quality health care for its beneficiaries.

The goal of the Skilled Nursing Facility Quality Reporting Program is to use quality measures and standardized data to promote interoperability and give post-acute care providers access to longitudinal information so they can better facilitate coordinated care, improved outcomes, and overall quality comparisons. Measures reported under the program include functional status, skin integrity, medication reconciliation, and major falls. In addition, several measures are calculated using claims data, meaning facilities do not have to submit additional data for these measures. Under the program, skilled nursing facilities and all non-critical access hospitals swing-bed rural hospitals that fail to submit the required quality data to CMS are subject to a two percentage point reduction to their skilled nursing facility payments for that fiscal year.

[25] All Cause Harm Prevention in Nursing Homes Change Package, available at: https://qioprogram.org/sites/default/files/editors/141/C2_Change_Package_20181226_FNL_508.pdf

As required by law[26], the Skilled Nursing Facility Value-Based Purchasing Program will apply either a positive or negative incentive payment adjustment to skilled nursing facilities based on their performance of the program's readmissions measure. The program's incentive payments began on October 1, 2018, and aim to improve individual outcomes by rewarding providers that take steps to limit the readmission of their patients to a hospital. Also as required by law, CMS will make publicly available facilities' performance under the program, specifically including each skilled nursing facility's performance score and the ranking of skilled nursing facilities for each fiscal year.[27]

Moving Forward

Every nursing home resident has the right to be treated with dignity and respect, and we expect every nursing home to meet this expectation. While nursing facilities have made progress towards these goals, there continues to be a strong and persistent need for ongoing improvement efforts around patient safety and quality of care in nursing homes. CMS remains diligent in our duties to monitor nursing homes participating in Medicare and Medicaid across the country, as well as the state agencies that survey them, and we look forward to continuing to work with Congress, states, facilities, residents and other stakeholders to make sure the residents we serve are receiving safe and high quality health care.

[26] Section 1888(h) of the Social Security Act.
[27] Available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBP.html