DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

NOV 20 2018

The Honorable Charles E. Grassley
Chairman
Committee on the Judiciary
United States Senate
Washington, DC 20510

Dear Chairman Grassley:

Thank you for your letter regarding the role the Centers for Medicare & Medicaid Services (CMS) plays in ensuring that nursing home residents receive quality and patient-centered care. CMS shares your concerns regarding the care of society's most vulnerable citizens and makes resident safety our top priority in nursing homes and all facilities that participate in the Medicare and Medicaid programs. Every nursing home serving Medicare and Medicaid residents must keep its residents safe and provide quality care.

Monitoring patient safety and quality of care in nursing homes and other long-term care facilities serving Medicare and Medicaid beneficiaries is an essential part of CMS's oversight efforts and requires coordinated efforts between the federal government and the states. CMS works with state survey agencies in each of the 50 states, the District of Columbia, Puerto Rico, and other U.S. territories to perform surveys of participating providers. For nursing homes, state survey agencies inspect providers for compliance with Medicare and Medicaid health and safety standards related to both delivery and monitoring of care. The states also manage the intake of complaints and conduct investigations accordingly.

Facilities must meet state licensure requirements in addition to CMS statutory and regulatory requirements to be certified as a Medicare or Medicaid provider. The state survey agency, working on behalf of CMS, is usually the same agency responsible for both state licensure and Federal surveys and oversight. Therefore, these on-site surveys are often performed by the same state team at the same time, with the findings entered into two separate survey reports: one for state licensure purposes and one for Medicare and Medicaid compliance purposes. Utilizing the expertise of state officials to perform surveys means state agencies and officials have up-to-date information on health and safety risks at facilities and, as appropriate, can take direct action against facilities through state licensure sanctions as well as recommend federal enforcement actions and remedies in response to deficiencies in health and safety requirements.

We appreciate the ongoing work of the Government Accountability Office (GAO) and Office of Inspector General (OIG) to review this important process and will continue to work with them as we make improvements to our own oversight efforts. Based on GAO's recommendations to improve the quality and ease of state reporting, CMS has implemented a new computer-based

standardized survey methodology across all states, as you mentioned. This resident-centered survey process for nursing homes emphasizes evidence of potential quality of care issues and concerns identified through resident observation and interview. This process provides additional standardization and structure to help ensure consistency between surveyors while allowing surveyors the autonomy to make decisions based on their expertise and judgment.

CMS makes results of these surveys available online through both individual reports on the Nursing Home Compare website and through datasets on our Quality, Certification and Oversight Reports (QCOR) database and the Medicare data website.[1] Additionally, beginning in April of 2018, CMS now distributes monthly performance feedback reports to CMS Regional Offices and states regarding the new standard survey process. These reports identify reporting issues such as inconsistencies with federal processes, and are discussed at quarterly meetings with Regional Offices and states in their regions.

CMS has also taken other actions to improve the quality and timeliness of state agency reporting. CMS conducts surveys of states to determine whether states are identifying deficiencies correctly, investigating compliance effectively, and meeting their other obligations. The CMS Regional Offices conduct formal assessments annually of each state survey agency's performance relative to measures included in the State Performance Standards System (SPSS). The SPSS provides a framework to organize and measure important aspects of state survey activities and is comprised of three domains: frequency, survey quality, and enforcement and remedy. These three areas also support our efforts to standardize and promote consistency among state survey agencies.

CMS recently revised the process for federal oversight surveys conducted of state survey teams to add areas of concern that federal surveyors will examine to determine whether state surveyors are investigating for compliance effectively. In fiscal year 2018, CMS worked with states on three areas of concern: abuse and neglect, admission/transfer/discharge, and dementia care. In subsequent years, each Regional Office will identify concerns unique to its region using Quality Measure Data from Nursing Home Compare, QCOR, and Minimum Data Set (MDS) information. CMS also recently launched an initiative to evaluate the entire SPSS program to identify ways to improve state performance. This is an ongoing, large-scale effort aimed at improving the efficiency and effectiveness of measuring and improving state performance.

You also asked about the convenience of using the tools CMS has made available online to compare nursing facilities. We consider user-friendliness a top priority when designing tools to empower consumers to make informed choices about their health. Since 2008, CMS has published on its Nursing Home Compare website a set of quality ratings called the Five Star Quality Rating System, for each nursing home that participates in Medicare or Medicaid. This public reporting site is a practical tool for residents and their families to understand how CMS assesses nursing homes and to draw distinctions between high and low performing nursing homes.

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[1] Available at https://qcor.cms.gov/ and https://data.medicare.gov/, respectively.

CMS makes continuous improvements to Nursing Home Compare and the Five Star Quality Rating System to enhance and strengthen the comparison tool to provide the most accurate information to beneficiaries and their families. Throughout the years, CMS has added more information to Nursing Home Compare, including information on facility ownership, federal administrative sanctions against nursing homes, and the full text of nursing home health inspection reports. In 2015, CMS added a quality measure to report the incidence of re-hospitalizations among short-stay residents. Most recently in July of 2018, CMS began including the rates of hospitalizations for long-stay residents in each facility's "Nursing Home Compare Five-Star Ratings of Nursing Homes Provider Rating Report." CMS made this long-stay quality measure publicly available on Nursing Home Compare in October 2018 and will include it each facility's ratings calculation beginning in the spring of 2019.

In October of 2018, CMS resumed posting state and national average citations per nursing home health inspection available on Nursing Home Compare. CMS temporarily suspended posting this information until inspections were conducted under the new long term care participation requirements that went into effect last fall. To help users navigate and better understand the methods used to calculate the ratings, CMS published the "Design for Nursing Home Compare Five-Star Quality Rating System: Technical User's Guide" in July.[2]

CMS recently updated and enhanced the nursing home staffing information available on Nursing Home Compare. Nursing home staffing has a tremendous impact on the quality of care that residents receive. As you mentioned, data collection is critical in our ability to oversee the quality of treatment at facilities; to that end, we developed a new system for facilities to submit staffing and census information on the Nursing Home Compare tool that allows this information to be collected on a regular and more frequent basis—the Payroll-Based Journal (PBJ). The new staffing information is calculated using the number of hours facility staff are paid to work each day, rather than the numbers of hours facility staff work over a two-week period under the old system. Also, unlike the data calculated under the previous system, the data calculated under the PBJ system is auditable to ensure accuracy. The PBJ data provides unprecedented insight into how facilities are staffed, which can be used to analyze how facilities' staffing relates to quality and outcomes. CMS hopes these changes will improve the accuracy of public reporting and enable consumers to have a better understanding of how a facility is staffed on any given day.

The PBJ data has already helped CMS identify issues, such as significant variations in staffing between weekdays and weekends, and days with no registered nurse reported onsite. CMS is working diligently with nursing homes to address these issues. For example, facilities who report seven or more days with no registered nurse hours are now assigned a one-star staffing quality rating. We are also planning to use the PBJ data to inform surveyors' investigations to help determine if staffing is an underlying cause of any quality issues. And since the start of the PBJ program, we have been providing individualized feedback to each facility about their

[2] Available at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/downloads/usersguide.pdf.

staffing data for them to use to improve the accuracy of future submissions. We will continue to accumulate and analyze the data to ensure nursing homes are staffing their facilities appropriately in order to provide quality care to residents.

CMS also works with OIG to identify solutions that can improve CMS's oversight of nursing homes. In addition to the audits and evaluations conducted by the OIG, the OIG maintains a List of Excluded Individuals/Entities (LEIE) and CMS has the authority to deny or revoke a facility's Medicare enrollment if an owner of the facility is included on the OIG's LEIE or has a felony conviction. While under existing authority CMS cannot deny or revoke a facility's Medicare enrollment as a result of its owner being affiliated with a previously-revoked facility, we proposed a rule in 2016 that would allow CMS to deny a facility's Medicare enrollment if an owner is affiliated with a previously-revoked facility. We received many comments on that proposed rule and are examining options to address this issue in a way that does not place undue burden on providers or compromise access to care.

CMS remains diligent in its duties to monitor nursing homes participating in Medicare and Medicaid across the country. We look forward to continuing to work with you to make sure the residents we serve are receiving safe and high quality health care. If you have any further questions, please contact the CMS Office of Legislation at (202) 690-8220.

Sincerely,

Seema Verma