NEAL R. GROSS & CO., INC.

RPTS WOJACK

HIF249020

EXAMINING FEDERAL EFFORTS TO ENSURE QUALITY OF CARE AND RESIDENT SAFETY IN NURSING HOMES

THURSDAY, SEPTEMBER 6, 2018

House of Representatives

Subcommittee on Oversight and Investigations

Committee on Energy and Commerce

Washington, D.C.

The subcommittee met, pursuant to call, at 10:15 a.m., in Room 2322 Rayburn House Office Building, Hon. Gregg Harper [chairman of the subcommittee] presiding.

Members present: Representatives Harper, Griffith, Burgess, Brooks, Walberg, Walters, Costello, Carter, Walden (ex officio), DeGette, Schakowsky, Castor, Clarke, Ruiz, and Pallone (ex officio).

Also present: Representative Bilirakis.

Staff present: Jennifer Barblan, Chief Counsel, Oversight and Investigations; Samantha Bopp, Staff Assistant; Lamar Echols, Counsel, Oversight and Investigations; Ali Fulling, Legislative Clerk, Oversight and Investigations, Digital Commerce and Consumer Protection; Christopher Santini, Counsel, Oversight and Investigations; Jennifer Sherman, Press Secretary; Julie Babayan, Minority Counsel; Jeff Carroll, Minority Staff Director; Tiffany Guarascio, Minority Deputy Staff Director and Chief Health Advisor; Chris Knauer, Minority Oversight Staff Director; Jourdan Lewis, Minority Staff Assistant and Policy Analyst; Kevin McAloon, Minority Professional Staff Member; and C.J. Young, Minority Press Secretary.

Mr. Harper. We will call to order today's subcommittee hearing, Oversight and Investigations, and our hearing today is on Examining Federal Efforts to Ensure Quality of Care and Resident Safety in Nursing Homes. I want to welcome each of our witnesses that are here today, and at this point I am going to recognize myself for our opening statement.

So this a very important subject and the subcommittee continues to work in examining whether the federal government is meeting its obligations to ensure that residents in nursing homes across the country are free from abuse and receiving the quality of care that they deserve and respect.

Protecting our most vulnerable citizens is among the most fundamental responsibilities entrusted to the federal government and it is also a responsibility that we as Americans all share.

The Centers for Medicare and Medicaid Services, CMS, is the federal agency tasked with ensuring nursing home residents are protected and well cared for, and CMS largely relies on the efforts of State survey agencies to verify that nursing homes are meeting federal standards for quality and safety.

However, reports issued by the Department of Health and Human Services Office of Inspector General and the Government Accountability Office, along with all too frequent press reports,

detail horrible cases of abuse and neglect occurring in nursing homes raises questions as to whether CMS is fulfilling its obligations to residents. For example, in 2014, OIG found that based on its review of more than 650 medical records of Medicare beneficiaries that were receiving care in a nursing home, approximately one-third of residents experienced some type of harm during their stay. According to OIG, nearly 60 percent of this harm was either clearly preventable or likely preventable.

Last year, reports emerged out of Florida of the deaths of at least a dozen residents of the Rehabilitation Center at Hollywood Hills after the facility's air conditioning system failed in the immediate aftermath of Hurricane Irma. According to state regulators, temperatures at the facility reached nearly a hundred degrees and the facility deprived residents of timely medical care despite being located across the street from a fully functioning and functional hospital. CMS described the events at this nursing home as a complete management failure and terminated the facility from the Medicare and Medicaid programs noting that the conditions at the facility constituted an immediate jeopardy to residents' health and safety. Previously, this facility's owner entered into a settlement agreement with the federal government to resolve allegations he and his associates had paid kickbacks and performed medically unnecessary treatments to generate Medicare and Medicaid payments at another Florida healthcare facility in which he had an ownership interest.

Despite this history and last year's tragedy at that person's rehabilitation center, we have learned that the facility's owner continues to maintain an ownership interest in at least 11 facilities participating in the Medicare and Medicaid programs.

It can't be emphasized enough that it should not take a tragedy like what we have seen at the Rehabilitation Center at Hollywood Hills to make CMS mindful or take action in response of conditions at nursing homes that threaten residents' well-being. However, the committee's oversight and reports issued by OIG and GAO suggest that this isn't necessary the case.

Improving care for vulnerable populations including the care provided to nursing home residents has been identified by OIG as a top management challenge for over a decade. We want to know why this continues to be a top management challenge, what steps CMS is taking to improve efforts to enforce existing regulatory requirements, and how the agency is addressing any gaps in its oversight.

At the same time, we want to recognize the many, and I mean many, nursing homes that are providing their residents with high quality care. In advance of this hearing I checked in with Vanessa Henderson, executive director for the Mississippi Health Care Association, for an update on our facilities after Tropical Storm Gordon made landfall late last night on the Mississippi Gulf Coast. Ms. Henderson received reports every 2 hours throughout the night from 19 nursing homes in nine South

Mississippi counties. There were no major issues. They were well prepared.

When Hurricane Katrina devastated the Mississippi Gulf Coast, now 13 years ago, there was no fatality or major problem at a nursing home in Mississippi. And I am proud of these successes in my home state. What are the best practices being utilized at these facilities that if applied everywhere could yield positive outcomes for nursing home residents?

I look forward to hearing from each member on our panel on ways we can improve our federal oversight of nursing homes to ensure that CMS is protecting seniors from abuse and neglect in nursing homes and using its authority in a fair and efficient manner. I thank you for your testimony today and I now recognize the ranking member of the subcommittee from Colorado, Ms. DeGette, for 5 minutes.

Ms. DeGette. Thank you so much, Mr. Chairman. I guess as proof that this subcommittee often, most often, works in a bipartisan way, my opening statement is pretty much exactly the same opening statement you just made down to the example of the Hollywood Hills tragedy after Hurricane Irma when 14 people died. So I am going to submit my written statement for the record, I just want to make a couple of observations. The first one is some of us have been on this subcommittee for many, many years and those of you who have been here you know that for all of these years we have struggled to address the issue of quality

care at nursing homes. Both the IG at HHS and also the GAO have consistently raised issues over the years about how the states and CMS oversee the nursing home industry and every so often we have a real tragedy like this Hollywood Hills tragedy.

But then, you know, you have got to wonder how many more facilities are like this and what are we doing to make a permanent effort. It just seems like we haven't turned the corner to get where we need to be in providing effective oversight in this sector of care. For example, just today, the Inspector General in written testimony mentions a statistic that I find really troubling. Fully one-third of Medicare residents in a skilled nursing home experienced harm from the care that they received and half of those cases were actually preventable.

So we do this over and over again, but yet, yet, one-third of Medicare residents have experienced harm. Now the IG has made recommendations for how to improve these issues. CMS needs to articulate to us today what concrete steps the agency is making to improve this. I also want to know what progress CMS is making on implementing the updated health and safety regulations that were finalized in 2016 after a lengthy rulemaking process.

It took years and a lot of public feedback, but in 2016 CMS did update the federal nursing home regulations to improve planning for resident care, training for staff, and protections against abuse, among other issues. But now as CMS is implementing these new rules, the agency has taken a series of actions that

have led consumer groups, state attorneys general, and others to question whether CMS is doing enough to strengthen and enforce federal standards. Here is a couple of examples: Last year CMS announced that it had imposed a moratorium on the enforcement of many of these regulations. In other words the agency is restraining itself from using some of its most effective enforcement tools against those who violate those new rules designed to protect vulnerable nursing home residents.

I must say CMS has to commit itself to implementing and enforcing its own regulations. That sounds kind of like a ridiculous thing to say but it is true, because as I said the core issue is here that frail and vulnerable people are harmed when nursing homes fail to meet our standards. And I don't think any of us wants to wait until the next natural disaster or other disaster exposes some kind of a deficiency that kills dozens of people.

I want to thank the witnesses for being here today. I want to thank the Inspector General and the GAO for your body of oversight of work on nursing homes, and I hope that we won't be back here again next year or in 5 years to talk about how more people have died. Thanks, and I yield back. Mr. Harper. The gentlewoman yields back.

The chair will now recognize the gentleman from Oregon, the chairman of the full committee, Mr. Walden, for 5 minutes.

The Chairman. Thank you very much, Mr. Chairman. Thanks

for holding this hearing on this topic that is very important to all of us across the country.

I think it is important to put it all in context as well. According to information released by the Centers for Medicare and Medicaid Services, more than three million individuals rely on services provided by nursing homes at some point during every year. And on any given day, 1.4 million Americans reside in more than 15,000 nursing homes across our country and the overwhelming majority of these nursing homes provide high quality, lifesaving care to their residents. We know that too.

I have heard from many seniors and their families in my district about how they or their loved ones are receiving excellent, around-the-clock care at their nursing homes and they go above and beyond. One provider I spoke with recently has a facility down in Redding, California. And when the fires were threatening Redding he chartered buses, had them on the ready with 200 seats, made arrangements, and all of this was happening very, very quickly to be able to move patients, residents to a facility many miles away in Klamath Falls, Oregon, if need be. As it turned out he didn't have to do that evacuation, but they were ready. Unfortunately, this doesn't appear to be the case in all nursing homes.

We all know the discussion that has occurred around what happened at the Rehabilitation Center at Hollywood Hills, Florida, run by Dr. Jack Michel. That tragedy that occurred at

that facility during Hurricane Irma was the result of inexcusable management or mismanagement and it resulted in needless loss of life.

While many facilities in Florida had the right procedures in place and handled the hurricanes well, we need to make sure our federal oversight efforts are effective in detecting low quality, unsafe nursing homes while being mindful to not impose excessive regulatory burdens that in some cases don't help but cost a lot of money and tie up resources. So I think we need to look at that as well, what is working and what is not, to get to the underlying problems we have identified in the OIG and others have.

As Chairman Harper described, CMS is the federal agency responsible for ensuring the safety and quality of care provided to Medicare and Medicaid beneficiaries in nursing homes. CMS enters into these agreements with the states providing that state agencies will inspect nursing homes on CMS' behalf to determine whether the facilities are meeting federal requirements.

And so this is done by the states. However, CMS may not always be effectively overseeing that work that these agencies do on behalf of the federal government. Over the last decade or so, the Department of Health and Human Services Office of Inspector General and Government Accountability Office have both issued reports indicating CMS could improve its oversight of nursing homes.

For example, HHS OIG has examined whether states properly verify that deficiencies identified during nursing home inspections are corrected. In some instances, such as my state of Oregon, HHS OIG found the state properly verified that facilities corrected deficiencies after they were identified and during inspections.

Several of the reports on this topic, however, HHS OIG has found that state agencies elsewhere did not meet that standard of proper oversight. For example, a report issued this May estimated that in 2016 Nebraska failed to properly verify that deficiencies at nursing homes identified during state inspections were corrected 92 percent of the time. CMS needs to ensure that all state survey agencies are adequately conducting the survey process on their behalf.

We are looking forward to hearing what CMS is doing to improve its oversight of the survey process. We also look forward to hearing from GAO about their work and recommendations, especially their recommendations relating to CMS' oversight of state survey agencies. So the focus of today's hearing is to learn more about what CMS is doing to maintain consistency across the country and guarantee that all states are effectively surveying nursing homes on their behalf to ensure compliance with existing federal requirements.

We also want to know what we can do to help in these efforts. So it is important that CMS effectively enforce existing

requirements for nursing homes to protect and promote safety, especially in extreme cases like what happened at the Rehabilitation Center at Hollywood Hills. And lastly, I want to thank our witnesses for being a part of this important conversation. We very much value and appreciate your testimony.

With that Mr. Chair, unless anyone else wants the remainder -- Dr. Burgess chairs our Subcommittee on Health -- I yield the balance to you. Mr. Burgess. Well, thank you, Chairman Walden.

And I just want to mention that like Representative DeGette, in January of 2006 this subcommittee held a hearing, field hearing, in New Orleans, Louisiana, dealing with just this issue. So this morning it is important to see not just one of the lessons learned but how it is the implementation of those lessons and how really report not just to us, on us, how we are doing in overseeing the oversight that the agency is supposed to provide to the facilities that are taking care of our seniors.

So thank you, Mr. Chairman, for doing this hearing and I will yield back. Mr. Harper. The gentleman yields back.

The chair will now recognize the ranking member of the full committee, Mr. Pallone, for 5 minutes.

Mr. Pallone. Thank you, Mr. Chairman. Nursing home residents are among our most vulnerable populations who are often unable to care for themselves and require personal attention. Many of us have had loved ones in the care of nursing homes or

skilled nursing facilities so we can all appreciate the need to ensure these facilities are providing high quality care. Most of the time nursing homes are staffed by compassionate professionals who want to provide quality care to those who need it and these professionals are strong allies too in our efforts to ensure residents are properly taken care of.

As the Department of Health and Human Services Office of Inspector General points out in his testimony today, nursing homes offer enormous benefit by providing a place of comfort and healing to residents in fragile health, many of whom are insured by Medicaid. The best nursing homes provide excellent care and take seriously their duty to protect their residents.

That said, nursing home quality of care is a longstanding concern and we should always strive to conduct oversight of this sector in an effort to improve the overall quality of care. And over the past several years, HHS's OIG and the Government Accountability Office have both found problems in nursing home delivery of care and federal and state oversight. And that is not to say that we should be suspicious of all nursing homes, rather, certain providers have failed to ensure high quality care.

For example, OIG has found that when incidents of abuse or neglect occur some nursing homes fail to report them as required and GAO has identified gaps in nursing homes' emergency preparedness and response capabilities. We can and must demand better for our loved ones and that is why we must focus our

resources to weed out these bad actors so that residents are protected and the rest of the industry is not given a black eye.

And that is where the Centers for Medicare and Medicaid Services comes in. In exchange for participating in the Medicare/Medicaid programs, nursing homes must comply with federal standards related to health and safety. CMS is charged with overseeing nursing homes' compliance with those standards and the agency has enforcement mechanisms at its disposal. And among those standards are the ability to terminate a facility participation in Medicare and Medicaid if it does not comply, however, OIG and GAO have long raised questions about CMS' oversight of nursing homes.

For instance, OIG notes that CMS does not always ensure that abuse and neglect at skilled nursing facilities are identified and reported, and when a nursing home is cited for deficiency OIG has found that CMS does not always require them to correct the problem. Many of these same issues have been raised for several years so the committee needs to hear what progress CMS is making and what more needs to be done to better ensure quality of care.

CMS also relies on state survey agencies to conduct inspections of nursing homes on CMS' behalf, but some states have been better than others at ensuring high quality care. OIG's audits have revealed that several states fell short in investigating the most serious complaints and many had difficulty

meeting CMS' standards. Workforce shortages and inexperienced surveyors at the state level have also led to the understatement of serious care problems. And, hereto, OIG and GAO have found problems with CMS' oversight of the state agencies. We need to hear what CMS needs to do better or differently to ensure federal requirements are being followed.

And, finally, CMS has yet to finalize and enforce some 2016 regulations to update and strengthen the nursing home standards. These regulations address critical areas such as staff training and protections against abuse, among other issues. However, last year, CMS issued a moratorium on enforcement of many of these regulations. And it is important to hear the input of industry and consumer groups to ensure regulations are done right, but without actually enforcing these rules it is unclear how CMS will ensure the quality and safety of our nation's nursing homes.

So Dr. Goodrich needs to articulate today how CMS is considering the concerns of the industry and consumers while also meeting its responsibility to ensure high quality care in nursing homes. I yield back, Mr., I mean unless anybody else wants the time, but I don't think so. I yield back. Mr. Harper. The gentleman yields back. I ask unanimous consent that the members' written opening statements be made part of the record. Without objection, they will so be entered into the record. I also ask unanimous consent that members of the full committee on Energy and Commerce not on this subcommittee be permitted to participate

in today's hearing.

I would now like to introduce our witnesses for today's hearing. Today we have Dr. Kate Goodrich, the Director of the Center for Clinical Standards and Quality, and Chief Medical Officer at the Centers for Medicare and Medicaid Services. We welcome you today.

Next is Ms. Ruth Ann Dorrill, Regional Inspector General at the Office of Inspector General at the U.S. Department of Health and Human Services. Thank you for being here today.

And, finally, Mr. John Dicken, Director of Health Care at the U.S. Government Accountability Office.

You are each aware that this committee is holding an investigative hearing and when doing so has had the practice of taking testimony under oath. Do you have any objection to testifying under oath?

Let the record reflect that all three have indicated no.

The chair then advises you that under the rules of the House and the rules of the committee you are entitled to be accompanied by counsel. Do you desire to be accompanied by counsel during your testimony today?

All of the witnesses have indicated no.

In that case if you would please stand and raise your right hand, I will swear you in.

[Witnesses sworn.]

Mr. Harper. Thank you. You may be seated. You are now

under oath and subject to the penalties set forth in Title 18 Section 1001 of the United States Code. You may now give a 5-minute summary of your written testimony.

And we will begin with you, Dr. Goodrich, and you are recognized for 5. We would ask that you pull the microphone a little closer to you and make sure that the mike is on. And you know the light system is such when it gets to yellow you have 1 minute. Red, the floor will not open up, but do bring it in for a landing, okay. Thank you.

You may begin.

STATEMENT OF KATE GOODRICH, M.D., DIRECTOR, CENTER FOR CLINICAL STANDARDS AND QUALITY, AND CHIEF MEDICAL OFFICER, CMS; RUTH ANN DORRILL, REGIONAL INSPECTOR GENERAL, HHS OIG; AND, JOHN DICKEN, DIRECTOR, HEALTH CARE, GOVERNMENT ACCOUNTABILITY OFFICE (GAO).

STATEMENT OF KATE GOODRICH

Dr. Goodrich. All right. To Chairman Harper, Ranking Member DeGette, and members of the subcommittee, thank you for the opportunity to discuss CMS' efforts to oversee nursing homes.

Resident safety is our top priority in nursing homes and all facilities that participate in the Medicare and Medicaid programs. Every nursing home must keep its residents safe and provide high quality care. Monitoring patient safety and quality of care in nursing homes requires coordinated efforts between the federal government and the states.

To participate in Medicare or Medicaid, a nursing home must be certified as meeting numerous statutory and regulatory requirements including those pertaining the health, safety and quality. Compliance with these requirements for participation is verified through annual unannounced, onsite surveys conducted by state survey agencies in each of the 50 states, the District of Columbia, and the U.S. territories. When a state surveyor finds a serious violation of federal regulation they report it to CMS and swift action is taken.

In cases of immediate jeopardy, meaning a facility's

noncompliance has caused or is likely to cause serious injury, harm, or even death we can terminate the facility's participation agreement within as little as 2 days. Civil monetary penalties can also be assessed up to approximately $20,000 per day or per instance until substantial compliance is achieved. Other remedies could include in-service training or denial of payments.

For deficiencies that do not constitute immediate jeopardy, these deficiencies must be corrected within 6 months or the facility will be terminated from the program. Facilities are also required by law to report any allegation of abuse or neglect to their state survey agency and other appropriate authorities such as law enforcement or adult protective services.

When CMS learns that a nursing home has failed to report or investigate instances of abuse we take immediate action. For example, CMS issued a civil monetary penalty of almost $350,000 to one nursing home when a state surveyor found they did not properly investigate or prevent additional abuse involving eight residents.

We are always taking steps to enhance our quality and safety oversight efforts. Last fall, surveyors began verifying facility compliance with CMS' updated and improved emergency preparedness requirements. Facilities are now required to address location-specific hazards and responses, must have emergency or standby power systems and ensure they are operational during an emergency, develop additional staff training, and

implement a communications system to contact necessary persons regarding resident care and health status in a timely manner.

In addition, in 2016, CMS updated the nursing home requirements to reflect the substantial advances into theory and practice of service delivery that have been made since 1991 such as ensuring that nursing home staff are properly trained in caring for residents with dementia. Given the number of revisions, CMS has provided a phased-in approach for facilities to meet these new requirements. We are in the second of three implementation phases and we are taking a thoughtful approach to implementation and providing education to providers while holding them accountable for any deficiencies.

Promoting transparency is another key factor to incentivizing quality. By using a five-star quality rating system, our Nursing Home Compare Web site provides residents and their families with an easy way to understand meaningful distinctions between high and low performing facilities on three factors -- health inspections, quality measures, and staffing. In April of this year, we took steps to make staffing data more accurate. The new payroll-based journal data provide unprecedented insight into how facilities are staffed which can be used to analyze how facility staffing relates to quality and patient outcomes.

Under the new systems, facilities reporting 7 or more days in a quarter with no registered nurse hours or whose audits

identify significant inaccuracies between the hours reported and the hours verified will receive a one-star staffing rating which will reduce the facility's overall rating by one star.

CMS greatly appreciates and relies on the work of the Government Accountability Office and the HHS Office of the Inspector General to inform our efforts. We have implemented a number of recommendations in this area and we look forward to additional recommendations to help us continuously improve our programs.

For example, CMS implemented a new survey process last fall that provides standardization and structure to help ensure consistency between surveyors while allowing surveyors the autonomy to make decisions based upon their expertise and judgment. We expect every nursing home to keep its residents safe and provide high quality care. As a practicing physician that makes rounds in the hospital on weekends, many of my patients are frail, elderly nursing home residents, so I am personally deeply committed to the care of these patients.

CMS remains diligent in its duties to monitor nursing homes participating in the Medicare and Medicaid programs across the country 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 care. I look forward to answering questions you may have. Thank you.

[The prepared statement of Dr. Goodrich follows:]

**********INSERT 1**********

Mr. Harper. Thank you, Dr. Goodrich.

The chair will now recognize Ms. Dorrill for 5 minutes for the purposes of your opening statement.

STATEMENT OF RUTH ANN DORRILL

Ms. Dorrill. Good morning, Chairman Harper, Ranking Member DeGette, and other distinguished members of the subcommittee.

I have been visiting nursing homes on behalf of the OIG for 20 years. When you speak with the people who have chosen to spend their professional lives in these settings, they will tell you that nursing home care is incremental. By that I mean that the gains and the losses can be small and around the margins.

Nursing homes can be places of comfort and healing. They can make the difference between someone having 10 more good years or a downward spiral. But it's important to recognize that people who enter nursing homes are at low points at times of crisis. They often have not only an acute condition that landed them there in the first place, but they have many competing comorbidities and complex conditions on top of that.

Many of the facilities as you've said provide excellent care, but an alarming number of residents are subject to unsafe conditions, much of which is preventable with better guidance and government oversight. Our work has found widespread, serious problems in nursing home care and my remarks today will rest on three priority areas -- harm to nursing home residents, emergency preparedness of nursing homes, and the important role of the state agencies.

First, in regard to harm, OIG has expended extensive time

and focus on the problem of resident harm as it's been referenced already today, including harm from medical care known as adverse events. In a national study of hundreds of nursing homes, we found that a third of residents, 33 percent, one in three, were harmed by medical care -- infections, blood clots, aspiration -- and half of this harm, 59 percent, was preventable.

And an important point, one of the interesting things about this study to us was that most of these events weren't big, dramatic events that you think about when you think about harm or adverse events. Most of them were incremental. They were small. They were surrounding the daily, hourly care that's provided by certified nurse assistants and staffing throughout the nursing home.

And there are things that the staff didn't recognize and, in many cases, the family didn't recognize. The same is happening in hospitals. This low level, substandard care harms a tremendous number of people and we've recommended that CMS develop guidance and revise requirements for detecting and preventing this harm, the detection being a key component.

Residents also of course face abuse and neglect. In 2012, we found that only half of nursing homes were reporting allegations of abuse and neglect. And then we went back just last year in 2017 and looked at emergency room records and we found that it was still a substantial problem. There were many cases that were not reported by the nursing homes. We urged CMS

at that time to take immediate action to monitor claims and to enforce against those who fail to report. OIG also works in the law enforcement side with our partners to hold accountable those who victimize residents. Next, on emergency preparedness. So after Hurricane Katrina and other storms in 2005 we went into, we had found in looking at the deficiencies that almost all nursing homes met their emergency provisions. Ninety four percent were in compliance and yet when we visited a sample of homes who were actually affected by the hurricanes, we found that the plans weren't practical and up-to-date. That in many cases the nurses would pull out a pad and pen when they saw the hurricane coming as opposed to looking at the binder on the shelf.

We also found that once the storms hit and in their aftermath that whether the nursing homes evacuated or sheltered in place that they had problems with transportation, with staffing, with supplies, anything that you can imagine. We also found this for wildfires and for flooding.

When we went back, we also were struck by the fact that after additional storms -- Ike, Gustav in 2009-2010 -- we found essentially the same thing, no improvement besides additional guidance by CMS. We recommended that CMS develop targeted guidance in requirements and as Dr. Goodrich said state agencies began assessing homes for these requirements last November.

Finally, I want to further emphasize the critical role of the state agencies in citing deficiencies when homes aren't up

to snuff. In recent work, we found that seven of nine states did not consistently verify that homes actually corrected the deficiencies that the states had cited. In another study, we found that states weren't enforcing very critical core components, care and discharge planning, which are very important to patient outcomes. We recommended the states strengthen those procedures. And the report was in 2013, the recommendations were implemented just a few months ago in June of 2018.

In closing, the through line here is that while CMS has taken steps to create a framework for improvement, all progress will lie in the execution on the part of CMS, on the part of the state agencies, and on the part of the nursing homes. This means focused education and accountability from CMS and also staying alert to the impact of changes. Are the requirements understood, the new requirements by inspectors and homes are they practical? Do they improve care? None of that can really be assumed and the consequences are great. OIG is recommending that CMS do more to protect nursing home residents and we are committed to that as well. We have ongoing work assessing a number of areas and we thank you for your ongoing leadership in this area and for the opportunity today.

[The prepared statement of Ms. Dorrill follows:]

**********INSERT 2**********

Mr. Harper. Thank you, Ms. Dorrill.

We will now recognize Mr. Dicken for 5 minutes for the purposes of his opening statement. Thank you.

STATEMENT OF JOHN DICKEN

Mr. Dicken. Chairman Harper, Ranking Member DeGette, and members of the subcommittee, I'm pleased to be here today to discuss GAO's body of work on nursing home quality and the Center for Medicaid and Medicaid Services oversight of nursing homes.

For many years, GAO has reported on problems in nursing home quality and weaknesses in CMS' oversight. As early as 1998, GAO reported that despite federal and state oversight, certain California nursing homes were not sufficiently monitored to guarantee the safety and welfare of their residents. In the intervening 2 decades across more than two dozen reports, GAO has consistently found shortcomings in the care that some nursing home residents received and in federal and state oversight of nursing homes.

In response to identified weaknesses, CMS and state survey agencies have made a number of changes in their oversight. Inspection protocols have been updated, enforcement tools have been revised, and consumers have been provided more information to compare nursing homes. Yet, we continue to see mixed results in indicators intended to assess the quality of care. Further, we lack full assurance of these indicators including information made available to consumers are consistently based on accurate data and we remain concerned that the prevalence of serious care problems remains unacceptably high.

In my remaining time I'd like to briefly summarize key takeaways from GAO reports issued in 2015 and 2016 that examine trends in nursing home quality, information made available to consumers for comparing nursing homes, and changes CMS had made to its oversight activities. I will also note CMS' responses to recommendations we made.

First, we found that data on nursing home quality showed mixed results. We found an increase in reported consumer complaints through 2014, suggesting that consumers' concerns about nursing home quality increased. In contrast, trends in care deficiencies, nurse staffing levels, and clinical quality indicators through 2014 indicate potential improvement.

Second, we found data issues complicated the ability to assess quality trends. For example, at that time CMS allowed states to use different survey methodologies to measure deficiencies in nursing home care. GAO recommended CMS implement a standardized survey methodology across states and in November 2017 CMS completed national implementation. Further, GAO recommended CMS implement a plan for ongoing auditing of quality data that had been self-reported by nursing homes. The agency concurred and has begun auditing staffing data that now relies on payroll-based reporting, but CMS does not have a plan to audit certain other quality data on a continuing basis.

Third, in the 2016 report we found CMS did not systematically prioritize recommended changes to improve its Nursing Home

Compare Web site. In several factors it limited consumers' ability to use CMS' five-star rating system. CMS agreed with these recommendations and earlier this year completed actions establishing a process to prioritize website improvements and adding explanatory information about the five-star system. But CMS has not yet acted on other recommendations including providing national comparison information that could help consumers better make distinctions between nursing homes.

Fourth, CMS had modified certain oversight activities at the time of our 2015 report and those steps have continued. Some modifications expanded activities such as creating new training for state surveys on unnecessary medication use, others reduced existing activities. For example, CMS reduced the scope of federal monitoring surveys which may decrease CMS' ability to monitor whether state survey agencies understate serious care deficiencies. Similarly, CMS reduced the number of homes designated as special focus facilities which may limit its ability to monitor homes with poor performance. GAO recommended CMS monitor the effects of these modifications and CMS indicates it is beginning to take steps to do so.

In closing, addressing the long-term concerns that nursing residents receive unacceptable care requires sustained federal and state commitment. We maintain the importance of monitoring to help CMS better understand how oversight modifications affect nursing home quality and to improve its oversight given limited

resources.

Chairman Harper, Ranking Member DeGette, and members of the subcommittee, this concludes my prepared statement. I'd be pleased to answer any questions that you may have.

[The prepared statement of Mr. Dicken follows:]

**********INSERT 3**********

Mr. Harper. Thank you, Mr. Dicken.

This is now the members' opportunity to ask questions of each of you to learn more about this very important issue, so I will recognize myself for 5 minutes.

Ms. Dorrill, HHS OIG has identified improving care for vulnerable populations including the care provided to individuals in nursing homes as a top management challenge for a decade. Could you expand on this and tell us why ensuring nursing home residents receive the proper standard of care continues to be such a longstanding challenge for HHS and specifically CMS?

Ms. Dorrill. Yes, thank you for the question. It certainly is true that we have considered this a top management challenge for years and we would love to have that removed from the list. But unfortunately the problems remain. And I think it is important to note that although so many of these problems are longstanding that we are in a different place in time so the heavy lift with revising recommendations that has been done, when I said in my statement that we have a framework I think that's correct. And so we are at a different place than we were when we cited those TMCs over the years.

Mr. Harper. Is that a better place?

Ms. Dorrill. Yes. I think it's a first step, absolutely. And that but the proof will be in the execution of that, that sometimes a requirement and the actions of the homes just like emergency planning can be miles apart. And so, but that first

step was an enormous one and an important one. And so we would hope as we see execution over the next couple of years that we might be able to eliminate this concern from our top management challenges.

Mr. Harper. Do you see now that you and CMS are all on the same page?

Ms. Dorrill. It's a great question, yes and no. Yes, on some factors we feel that in respect to our adverse events the harm from medical care that CMS has been proactive in they pulled us into the process of providing that guidance based on our expertise and have laid out very explicit instructions for nursing homes and surveyors. In other areas I wouldn't grade them as highly.

Mr. Harper. Mr. Dicken, I would like to ask you a similar question. Given GAO's substantial body of work examining federal efforts related to nursing home quality of care, have any issues stood out to you as being long-term challenges for CMS?

Mr. Dicken. Yeah, thank you. And I think as you note that we do have a long-term body of work and many of those same types of issues have occurred. We are pleased that over the years CMS has implemented many of the recommendations we've had and made a number of changes. Certainly we've seen improvements in things like training of surveyors, a more standardized methodology for surveyors. We do continue to see that there's important need to make sure that information that CMS is receiving is accurate

and that they're using it for assessing states consistently.

And very important that as there are a number of changes occurring over the years that CMS and others continue to monitor to see what the effects of those changes actually are, both in some of the improvements and the enhancements that have been made as well as some of the reductions in oversight that have been made.

Mr. Harper. All right. Let me just follow up on that just a little bit if I can. Are there any aspects of CMS' efforts relating to nursing homes that GAO's work may have touched on would you believe merit additional attention?

Mr. Dicken. Well, we do still have a number of open recommendations that CMS has taken some steps in, one, in trying to make sure the information's more accurate. I think Dr. Goodrich mentioned that they have now much more verifiable information on staffing and are using that to more thoroughly look at and use inspections of staffing.

There are other areas still though, however, where they still need to make sure that getting accurate information and of monitoring those effects.

Mr. Harper. And, Dr. Goodrich, if I can ask you, you know, a question. Obviously in my opening statement I mentioned the terrible tragedy in Florida at Hollywood Hills at the Rehabilitation Center. And I know CMS terminated the facility from Medicare and Medicaid and has, you know, obviously recognized

how horrible that is.

The owner of the facility still has an ownership interest in 11 other facilities. Under CMS' current authority, is there anything preventing him from opening a new or additional nursing home facility?

Dr. Goodrich. So thank you for the question. The tragedy at Hollywood Hills was just that, devastating tragedy that should never have happened. As has been said before, it was a complete management failure. As I understand the facts of this case, there's nothing in Medicare that prevents Dr. Michel -- if I'm saying his name right --

Mr. Harper. Yes.

Dr. Goodrich. -- from having ownership interest in Medicare facilities. Medicare can only bar an individual who has been convicted of a felony or who is on the OIG exclusion list.

Mr. Harper. In light of Dr. Michel's history, do you believe you need additional tools that can restrict based upon something less than a criminal conviction?

Dr. Goodrich. So this is not my exact area, but I am aware that CMS issued a proposed rule in 2016 to further enhance our program integrity abilities related to this area. We received a number of comments on that rule and we are currently considering them in terms of how to move forward.

Mr. Harper. Thank you, Dr. Goodrich.

The chair will now recognize Ranking Member DeGette for 5 minutes.

Ms. DeGette. Thank you.

Ms. Dorrill mentioned that updating the recommendations is going to be the first step to trying to solve this problem. And as I mentioned in my opening statement, in 2016 CMS issued regulations that updated the federal health and safety rules for nursing homes.

I know, Dr. Goodrich that CMS is now in the process of implementing those regulations. I think the one you just referred to is probably one of them. You said that in your testimony these changes are the first comprehensive updates of the nursing home regulations since 1991; is that right? Yes Dr. Goodrich.

Dr. Goodrich. Sorry. That is correct.

Ms. DeGette. And so I am assuming that a lot has changed in the industry that would necessitate an update to those rules and I would assume that the 2016 regulations were designed in part to reflect the advancements and improve how the industry provides quality care to nursing home residents; is that correct?

Dr. Goodrich. Yes, that is correct.

Ms. DeGette. And as I said in my opening statement, since the rules have been finalized CMS has taken several actions that could delay some of them or roll them back altogether. First of all, the rules were designed to be implemented in phases, but

not all the phases have been implemented yet.

Second, CMS now has issued a moratorium on enforcing some of those rules, and, finally, last year CMS launched a review of nursing home regulations to or requirements to determine whether any of them placed procedural burdens on facilities. So it sounds like maybe some of these proposed rules will never be implemented; is that correct?

Dr. Goodrich. We are currently in the process as you mentioned of implementing the rule that we finalized in 2016. We are on target for implementing all three of the phases and that is underway now.

Ms. DeGette. Okay. And what is your timeframe for implementing all of the phases?

Dr. Goodrich. So phase 1 was implemented shortly after the publication of the final rule in 2016. This was really the things that nursing homes were already doing or were very simple to achieve.

Ms. DeGette. Okay.

Dr. Goodrich. Phase 2, we began implementation and surveying and enforcing on November 28th of 2017, so that is underway now. We've surveyed about --

Ms. DeGette. It has been about a year.

Dr. Goodrich. It's been about a year and phase 3 begins in November of 2019.

Ms. DeGette. And how long will that take?

Dr. Goodrich. So nursing homes are expected to be compliant with the phase 3 requirements by November of 2019. So at that time that will be the expectation.

Ms. DeGette. Okay. And so let me just ask the question again. Do you anticipate that all of the 2016 rules will be implemented?

Dr. Goodrich. Yes, we are on track to implement the 2016 final rule.

Ms. DeGette. Okay. Now I want to ask you a question about a CMS proposal that might prohibit nursing home residents from being able to bring a lawsuit. There is a rule that bans pre-dispute arbitration agreements and CMS has signaled it may remove it. In other words CMS is proposing to remove what I consider to be a consumer protection rule that was designed to make sure that nursing home residents could go to court or could join other people in lawsuits to settle grievances and that they wouldn't be forced into arbitration.

I know a lot of groups like the AARP have expressed concerns about this proposed change. What is the status of that? Does CMS intend to do that and why?

Dr. Goodrich. So as you mentioned as part of the 2016 final rule we did impose a ban on pre-dispute arbitration.

Ms. DeGette. Yes.

Dr. Goodrich. Shortly thereafter, Department of Health and Human Services was sued for an injunction, a preliminary and

permanent injunction to stop CMS from enforcing that ban on pre-dispute arbitration. The court granted a preliminary injunction in November of 2016, so we currently cannot enforce what we finalized --

Ms. DeGette. Did by court order?

Dr. Goodrich. Yes.

Ms. DeGette. And what is the status of that lawsuit, do you know?

Dr. Goodrich. I'm not certain of the status but the injunction is still in place so we are not able to enforce.

Ms. DeGette. If you could get us the status of that lawsuit that would be --

Dr. Goodrich. Certainly.

Ms. DeGette. -- very helpful to us because my view and I think Congresswoman Schakowsky would really agree with me about this as one of the most effective ways to address if we see rampant nursing home abuses is when patients can bring class actions against some of these bad actors. And, you know, these families they are going into nursing homes, they are being asked to sign these arbitration agreements. They are so desperate to get the health -- as I think all of you have said, these are families in crisis many times and so they just sign it and then they have signed away their legal rights.

So we will do everything we can, I think, to make sure that we can enforce that 2016 rule that people don't have to be forced

to sign arbitration agreements. With that I yield back.

Mr. Harper. The gentlewoman yields back.

The chair will now recognize the gentleman from Oregon, the chair of the full committee, Mr. Walden, for 5 minutes.

The Chairman. Thank you, Mr. Chairman. And I want to thank our witnesses. We have another hearing going on downstairs and so some of us have to bounce back and forth.

Dr. Goodrich, a September 2017 data brief issued by the OIG indicated that there was a significant amount of variation with respect to how state survey agencies classified the complaints they received. For example, data compiled by the OIG showed that in 2015 there were three states that prioritized complaints as being immediate jeopardy at least 40 percent of the time, while eight states did not designate any of their complaints as immediate jeopardy.

Can you explain why there seems to be such a variation in how states prioritize complaints and what is CMS doing to ensure that complaints and deficiencies are addressed in a more consistent manner?

Dr. Goodrich. Yes, thank you for the question. So, first, I want to say we very much appreciate the work of the OIG and the GAO in the oversight of our programs. They really help to make our programs better and we have concurred with the vast majority of their recommendations particularly on this issue around state service oversight, state agency oversight.

So we are undertaking actively a number of actions to address exactly these recommendations. So number one, CMS regional offices do meet quarterly with the state survey agencies to discuss issues, look at trends and how they're performing, any concerns that they may have. We also recently undertook an effort to really overhaul our federal oversight surveys.

We are required to conduct federal oversight surveys of about five percent of state surveys or at least five state surveys and we've been doing this for awhile, but we've undertaken an effort beginning in April of this year to revise that process in response to what we learned from the OIG as well as the GAO. So that's underway now as well.

We also give monthly feedback reports to the state survey agencies that we began in April of this year which allow them to understand where their own deficiencies are, where there may be patterns of inconsistencies or where they're not appropriately citing deficiencies as they should. And this has really been made possible by the new standardized software-based survey process that we implemented last fall across the country.

The Chairman. Ah, okay.

Dr. Goodrich. And then finally we are in the process right now of really overhauling the State Performance Standards System. This is a system that we've had underway for awhile, but again in response to the recommendations from the OIG and the GAO we began an effort again in April of this year to evaluate this entire

program to identify ways to improve it. It's a very large-scale effort, will take at least a year to do but is well underway. And it's really focused on improving the efficiency and the effectiveness of measuring and improving state performance.

The Chairman. Right.

Dr. Goodrich. So we're very happy that we have these recommendations and that we're moving forward on them.

The Chairman. Good, thank you. You know, admittedly, this is old, but my mother spent her last few months in a nursing home in our hometown 28 years ago. And I spent a lot of time in and out as you do with a parent and I was always struck by how much time the people that were giving health care had to spend on paperwork. And they would be off in the cafeteria and I went over, and I was in state legislature at the time, and I said what is all this, and just reams of paper, paper, paper.

And I thought at some point, here, as public policy people we want what everybody wants is quality safe care especially for this vulnerable and difficult fragile population and sometimes government just overreacts and says we need a new rule, we need a new regulation, we need another something which in the end eats up the resource that is hard to get.

It is hard to, as we all know there are medical shortages in terms of nurses and aides and everybody else and it just struck me that would my mother have been better off with less reporting and paperwork and somebody that actually was checking on her more

often. Do you know what I mean? And we have got to have both, it is finding this right balance. But boy, I hope somebody is looking at just the layer, a layer, a layer we tend to add on to address a single problem that may occur in Florida and so we think we have to do this everywhere.

And looks at are there some things that we could peel back that would actually allow improved quality of care and then what are the real management tools we need and make sure they are being enforced effectively in this process. It is hard, I know, but I have seen it firsthand. My parents, both my parents and my mother-in-law and over the years and, you know, you realize it is a difficult population and very fragile medically. Things happen and mistakes are made and there are some bad actors.

And so I just hope as you all are doing your work somebody is looking at that angle as well so the measurements and the tools for enforcement are effective but make sense too. So, Mr. Chairman, I yield back.

Mr. Harper. The gentleman yields back. The chair will now recognize the gentlewoman from Florida, Ms. Castor, for 5 minutes.

Ms. Castor. Thank you, Mr. Chairman. I think this investigation by the committee is very important on nursing home resident care and the quality of our skilled nursing centers across the country and I appreciate the focus on emergency preparedness. It has not been a year since Hurricane Irma swept through and I think it is important for us to go through what

CMS is doing, what states are doing. One thing that should not be done has become clear here as was reported by the AP earlier this year. As Hurricane Irma bore down on Florida, Governor Rick Scott gave out his cell phone number during a conference call with administrators of the state's nursing homes and assisted living facilities. He told them to contact him if they ran into problems and he would try to get help.

So they did 120 times according to phone records released earlier this year, not last year. Nearly all the calls went directly to voice mail before being returned. The Associated Press reached 29 of the callers and found that in numerous cases the Governor's offer to personally intervene may have slowed efforts to get help and fostered unrealistic and potentially dangerous expectations that Scott could resolve problems.

Irma knocked out power across much of Florida as its strongest winds swept from Key West to Jacksonville, so most of the skilled nursing centers asked for restoration of electricity. But Florida is served by private electric companies and municipal utilities and none are directed by the state, so the Governor's office could only request that particular nursing homes be given priority.

Twelve patients later died of overheating at a nursing home that called Scott's cell phone three times. Its administrators say Scott's staff didn't get them help restoring the air conditioning but we know it was a significant management failure

as well by the owners of Hollywood Hills. This cannot be the answer for emergency preparedness.

So I understand now there are new requirements that went into effect in November of 2016. CMS is now surveying states. That began last year. What have we found? Are the states following through? I will let you begin, Doctor.

Dr. Goodrich. Absolutely. Thank you for the question. As you mentioned, we did finalize the emergency preparedness rule in November of 2016. This applied to all Medicare-certified facilities certainly including long-term care facilities or nursing homes. We began verifying that compliance in November of 2017.

So far we have surveyed about 75 percent of facilities. We anticipate we will have surveyed across the country a hundred percent of facilities by February of 2019. As you noted, there is a need for proper communications systems when there is a disaster and one of the components of the emergency preparedness rule that facilities are now required to adhere to is to develop and maintain communications systems to contact appropriate staff and authorities.

Ms. Castor. So are you finding now in the surveys that they are adhering to the new requirements?

Dr. Goodrich. So we are finding currently that there have been some providers that have been cited for noncompliance so we are working with them to bring them into compliance rapidly.

That is an area that they are required to adhere to. Currently, we are not finding that that is one of the most commonly cited deficiencies, but it is something that we are surveying for actively.

Ms. Castor. Thank you. I mean states have a critical role here and I am concerned with certain states not following through with requirements. For instance, OIG's audits have found that some states fell short in investigating the most serious complaints in nursing homes. Ms. Dorrill, what are the nature of these complaints and what should we expect the states to do in response?

Ms. Dorrill. The complaints ran across the board and then half of them were associated with high priority or immediate jeopardy, so serious complaints. And so I think the issue at hand is that states have to be held accountable. Dr. Goodrich talked a bit about that system and I think it's critical to all these pieces coming together that the states are understanding the new requirements and effectively enforcing those in the homes.

Ms. Castor. Do you believe CMS is holding states accountable when they do not follow through with their responsibilities?

Ms. Dorrill. So much of this is new, we'll certainly be looking at it. But so much of the new requirement in the guidance is just new within the last, you know, 9 months and so we don't know but we certainly have pointed out weaknesses. And we think

that it's a two-pronged approach. It's education and it's also ensuring that there's some kind of accountability on the part of the states to ensure that they follow through.

Ms. Castor. Thank you. I yield back.

Mr. Harper. The gentlewoman yields back. The chair will now recognize the gentleman from Virginia, the vice chairman of the subcommittee, for 5 minutes.

Mr. Griffith. Thank you very much, Mr. Chairman. I greatly appreciate it.

Dr. Goodrich, my colleagues, Congresswoman Black, Congressman Adrian Smith, Lujan and Crowley and I recently introduced the Reducing Unnecessary Senior Hospitalization Act of 2018 which seeks to improve quality in nursing homes by providing quality acute care at patients' bedsides via telehealth instead of transferring them to the hospital. By CMS' own calculations, two-thirds of hospital transfers are avoidable leading to increased costs to Medicare and negatively impacting health outcomes and quality of care. What are your thoughts on the potential for complementing current nursing home staff with emergency trained first responders utilizing telehealth to connect physician specialists, i.e., emergency physicians that might not otherwise be available to this patient population?

Dr. Goodrich. So thank you for that question and letting me know about this pending legislation. So we do understand that as you mentioned transfers to the hospital that's, you know,

that's a very disrupting event for a nursing home patient and many of them are avoidable. This is something we actually measure as part of our quality reporting programs so we're certainly aware that there's a significant level of admissions to a hospital.

So we would be very interested and willing to provide technical assistance to you and your staff on this legislation at your convenience.

Mr. Griffith. Well, I appreciate that very much and thank you. You know, I am really excited by telemedicine. Representing a fairly rural district, I can tell you that one of my small nursing home chains has implemented wound care by using telemedicine, so they have a wound care specialist who is available.

And one of their nurses will go in and see the patient who may have a bedsore or some other kind of injury and they are looking at through a pair of glasses that has a camera on it and the wound specialist wherever they are in the United States can see that wound, get a color picture, be able to then to tell the nursing home staff what needs to be done to make sure that that wound is being treated properly and taken care of. So I am really excited about telemedicine as a whole.

Let me go to your payroll-based journal for staffing, because I do think that sometimes there may be some confusion. And while we recognize that we want the staffing to be there so you all can use it as a tool, you mentioned it in your statement, Mr.

Dicken mentioned in his that there was, you know, the self-reporting hadn't worked because there was a difference.

But I think that may be a little unfair to CMS and to the nursing homes affected, to some of them. Not the bad actors but people that are really trying, because am I not correct that it is a slightly different standard? In self-reporting if you had a salaried employee who worked 50-55 hours a week they got to count that extra time, but under your report which I have no quarrel with, I am just saying they are different, you only count those folks at a maximum of 40 hours of being on the floor.

Likewise, if you have an LPN who is doing supervisory work, they don't get credit for their supervisory time where an RN would. Again no quarrel with the change, but just saying that to say that the old reporting system was intentionally underreporting might not be fair since it is really apples to oranges. Wouldn't you agree with that?

Dr. Goodrich. The previous reporting system was essentially a two-week snapshot that the nursing homes completed on a form during their recertification survey. The current system as you mentioned is based upon daily staffing levels of numerous different types of staff that the nursing homes have to report quarterly to CMS. And certainly as we were standing that up we had to make certain decisions around ensuring that what is reported is auditable back to the payroll so that it could be as it is required by law so that it could be as accurate as

possible.

So the situations you mentioned around a salaried employee, yes, we only count the 40 hours a week that they would be working.

Mr. Griffith. And I don't have any quarrel with that but to say that there was understaffing previously when you are using different metrics wouldn't really be fair to CMS or to some of the nursing homes. Wouldn't that be fair to say?

Dr. Goodrich. I would say it's very difficult to compare the two.

Mr. Griffith. Difficult to compare, okay.

The Commonwealth of Virginia partnering with healthcare providers developed a long-term care mutual aid plan which is a voluntary agreement among participating nursing homes that they will share supplies, resources, and house residents from other facilities if a serious need arises. We heard Chairman Walden say earlier that one of his nursing homes or a small chain had a facility in California and was looking to move patients to Oregon. This is actually a statewide system. Are you familiar with this type of plan and do you think it will work and do you think other states will adopt it?

Dr. Goodrich. I am not familiar with this kind of plan but we certainly would be interested to learn more and again our staff would be glad to follow up with you on this.

Mr. Griffith. Very good. Thank you so much.

I yield back, Mr. Chairman.

Mr. Harper. The gentleman yields back. The chair will now recognize the gentleman from California, Mr. Ruiz, for 5 minutes.

Mr. Ruiz. Thank you, Mr. Chairman. Taking care of seniors has been a big priority for me as a physician. I am an emergency medicine doctor, Dr. Goodrich, and now as a Member of Congress advocating for them here. And when a loved one is placed in the care of a nursing home, we trust and expect that they will receive high quality care and as we know many nursing homes do exactly that. But it is also clear from years of reports from OIG and GAO that there are problematic providers out there.

Ms. Dorrill, your office did groundbreaking work that identified instances of adverse events in nursing homes and you found that one in three Medicare beneficiaries experienced harm during their stay. So what kind of adverse events did these residents experience, can you elaborate on those?

Ms. Dorrill. Yes, thank you for the question. It really ranged the gamut. And that's actually a part of our message is that we found that nursing homes were focusing on just a small number of events, falls with injury, for example, and pressure ulcers, and they were excluding a broad range of events that were already happening that went unnoticed as harm. Things like blood clots and dehydration that can seem like subtle --

Mr. Ruiz. That they didn't identify and allowed it to persist for a time. How about medical errors, giving the wrong medication, et cetera?

Ms. Dorrill. Fourteen percent of our events involve medical error. When a lot of people think about adverse events they think it's all medical error. But one of the things that we've tried to promulgate is this notion that adverse events can occur from general substandard care. It's not really a mistake, it's just not doing the right thing.

Mr. Ruiz. So you say that half of these were preventable. Can you give me some examples of those that were not preventable that --

Ms. Dorrill. Yes. So, for example, if someone was given a medication and they were allergic to that and had a reaction but no one knew that they were allergic that was not information that the physician could have acted upon.

Mr. Ruiz. And so are these different adverse events not on the state agencies' survey lists? Why are they not looking for these?

Ms. Dorrill. I think that there's been a revolution and this is true for hospitals too in the whole notion of adverse events. And CMS has changed its hospitals provisions as well that I think there was just a narrow focus on a small number of events and people weren't thinking about harm more broadly.

Mr. Ruiz. So they weren't.

Ms. Dorrill. No.

Mr. Ruiz. They weren't looking for these different types of adverse events.

Ms. Dorrill. That's correct.

Mr. Ruiz. So I would like to turn to another quality of care concern. In your recent reporting, OIG again identified Medicare beneficiaries in nursing homes who suffered harm, this time from abuse and neglect, where still OIG found that, quote, a significant percentage of these incidents may not have been reported to law enforcement.

So I find this very troubling and so did you, or OIG, enough to issue an early alert to CMS about the findings. What are some of the immediate actions CMS can take to address these vulnerabilities?

Ms. Dorrill. Thank you. We first requested that they do what we did which is it's possible to look in the claims and find out a lot of these things are claims associated with abuse and neglect and that we suggested that CMS do that to monitor the situation. And then, secondly, we also suggested that they enhance their pursuit of the authority to be able to give remedies when these events were not reported.

Mr. Ruiz. Dr. Goodrich, what has the agency taken, what actions has the agency taken to address this finding?

Dr. Goodrich. So regarding the recommendation to look in the claims for emergency room services and matching those claims to skilled nursing facilities, that is something that we are currently exploring the feasibility of doing.

Mr. Ruiz. You haven't started it but you are just looking

into it.

Dr. Goodrich. We're exploring whether or not that's feasible to do to be able to have that information to the surveyors.

Mr. Ruiz. Well, by law, as an emergency physician if somebody reports any suspicion of abuse or neglect that has to go into the medical record and that has to be reported to the county officials and APS and all that so that would be a good place to start.

I have another question in terms of empowering the clients and consumers and also their families. Is there any requirement that when a patient gets or a person gets admitted to a nursing home during the orientation that they are given an understanding of their rights, of quality measures, resources, to understand more about what those quality measures are and also a way to report any concerns to a third party like an agency or CMS, is that a requirement, part of your requirements for CMS so that they know that and is that being implemented properly?

Dr. Goodrich. Yes. So yes, that is a requirement as part of our requirements for participation that residents or their, and their families or their surrogates be informed of their rights as soon as they are admitted into a nursing facility and that they are informed of their rights to file complaints with the state survey agency or with law enforcement.

Mr. Ruiz. Are they given the information on how to do that?

Dr. Goodrich. Yeah, it's supposed to be posted in the nursing home. Sorry, I'm not familiar with the details.

Mr. Ruiz. Yes, see that is the difference that Ms. Dorrill was saying. It is either posted or you have something in writing, but the true understanding and the implementation of that information is a different story.

So do we know if it is being conducted in a way where during the orientation they are being explained on how to file a complaint?

Dr. Goodrich. Yes. As part of the admission process in addition to everything about the plan of care in clinical care, one of our conditions or requirements for participation is around patient rights and being informed of those rights.

Mr. Ruiz. Thank you.

Mr. Harper. The gentleman yields back. The chair will now recognize the gentlewoman from Indiana, Mrs. Brooks, for 5 minutes.

Mrs. Brooks. Thank you, Mr. Chairman, and thank you for holding this very important hearing.

Ms. Dorrill, I would like as Chairman Harper talked about in his opening statement, I want to focus a little bit on my line of questioning regarding the owner of the facility where the 12 residents died in the aftermath of Hurricane Irma, the Hollywood Hills. Because it is my understanding that Dr. Michel -- is that how we say his name, or Michel? Is it Michel? Michel --

had been the subject of wrongdoing in the past including settling with the Department of Justice long ago, corporate integrity agreement, after being implicated in a scheme to receive kickbacks for providing unnecessary medical treatment to elderly residents and that was the '06 timeframe.

Can you please explain -- and I am a former U.S. Attorney so I have worked with HHS OIG. Can you explain what tools are available to you to exclude facility owners from owning nursing homes if obviously OIG had determined and there was a settlement and so forth, but they were involved in participating in this unlawful conduct or fraud, can you go into deeper detail about exclusion process?

Ms. Dorrill. Yes, just to say though, you know, I'm not in the Counsel's Office. I'm not an investigator but I'll do my best, that OIG has a number of tools at our disposal and this it's critical to us. It's the main part of our work that we hold wrongdoers accountable. And so I think the important thing to remember is that those tools are at our disposal and that it depends on the specific facts and circumstances of the case what direction we go.

But we certainly have the exclusion authority. We also have tools such as under the False Claims Act we have the ability to impose civil monetary penalties. We also have hundreds of criminal investigators who help their law enforcement partners to investigate criminal cases. So it's a broad range of activity

and core to our mission.

Mrs. Brooks. Can you talk a little bit though about the exclusion authority tool and how long the process takes, who ultimately makes the decision as to when a provider is on the exclusion list?

Ms. Dorrill. So for those who may not be familiar and again I'm not in the Counsel's Office, but the OIG can exclude individuals and entities from federal programs such as Medicare and Medicaid for various types of conduct set forth in statute including false claims. The primary effect of that exclusion is it will no longer pay for services and we maintain a database with all that information publicly. OIG has certainly excluded nursing home providers. We recently excluded a 13-facility nursing home chain. We have something like 70,000 excluded providers now, something like 1,600 just this fiscal year alone. So I don't know if that fully answers your question.

Mrs. Brooks. It doesn't require though a criminal conviction then for a person to be excluded or an entity to be excluded?

Ms. Dorrill. I'll need to take that question, I'd be so happy to, back to my Counsel's Office to make sure that I can give you accurate information there.

Mrs. Brooks. I think we would like to know more information about the exclusion process from Counsel's Office and from your office particularly relative to, you know, not only we had that

incident, but as I understand there are other incidents involving this particular provider let alone the Hollywood Hills incident. So I am interested in knowing how long the process takes, who makes the final decisions, what are the categories that a person can be excluded.

Then I would like to ask both you and Dr. Goodrich a little bit more about the emergency preparedness issues. We are reauthorizing what is called PAHPA, Pandemic All-Hazards Preparedness Act, and we are including in that a provision to have the National Academy of Medicine do an overview of emergency preparedness by hospitals but also long-term care facilities. And because as I am hearing you both say that while there might be plans in place that doesn't necessarily mean the execution of those plans happen.

And is that any -- do you believe there needs to be more attention to this emergency preparedness that we are not doing enough? Dr. Goodrich?

Dr. Goodrich. Thank you. Obviously this is, you know, a huge priority for us especially given the events of last year. So as we've mentioned we are in the process, in the early process of implementing that regulation and surveying facilities for that. So as you're working, doing your work on this area we'd be more than happy to give you technical assistance and talk through these issues with you. But we are early in the process and I think learning how it is going.

Mrs. Brooks. Okay, thank you.

Ms. Dorrill, anything further before my time is expired?

Ms. Dorrill. No, just asserting that we found significant problems with the emergency planning and appreciate your focus on that areas.

Mrs. Brooks. Thank you. I yield back.

Mr. Harper. The gentlewoman yields back. The chair will now recognize the gentlewoman from Illinois, Ms. Schakowsky, for 5 minutes.

Ms. Schakowsky. Thank you, Mr. Chairman.

If I sound a little impatient about this focus on nursing home and safety it is because I have been working on this issue since the mid-80s, including when I was in the state legislature in Illinois and ever since I have been here in Congress. There are some provisions in the Affordable Care Act that deal with nursing homes that I was successful in getting into the legislation. But I don't know how many GAO reports there have been. I don't know how many reports from oversight committees there have been about these persistent problems.

And as we enter into this age where more, you know, the aging of America, the graying of America, more and more people needing long-term care including nursing homes, it is hard for me to hear words like, this is an important first step. I mean we need to be making last steps now. We need to be getting at the heart of the problem.

Let me ask you, Dr. Goodrich, who has the primary responsibility to make sure that nursing home quality standards are met, states or CMS? And is it the policy of the Trump administration to shift more of the responsibility to the states?

Dr. Goodrich. So it is a shared responsibility between the states and CMS. We promulgate the regulations and then we oversee the state survey agencies in their implementation of the surveys of the nursing homes and the implementation of those regulations. And as I --

Ms. Schakowsky. Are we seeing more of a shift towards states or is this always standard?

Dr. Goodrich. Our process for overseeing health and safety for nursing homes remains the same. It hasn't changed. It remains a partnership in the way that I just described.

Ms. Schakowsky. What was the rationale behind no longer imposing financial penalties for each day of a violation? Couldn't that be seen as a weakening of a commitment to enforcement?

Dr. Goodrich. Specifically related to the civil monetary penalties what we were seeing over the last few years and what had been, I think, also recognized by others was that there was quite a bit of variation in how civil monetary penalties were being applied across the country. In some areas not being applied enough when they should have been and in other areas being applied in situations when actually should have had different enforcement

remedies applied.

So we sought to make that process more standardized and more uniform so that there was consistency across the country in the correct application of civil monetary penalties. And so last year what we did was we worked with the regional offices and we developed a civil monetary penalty tool so that survey agencies and our regional offices could go and use that tool which has essentially an algorithm in it to ensure that regions are consistently and accurately applying civil monetary penalties.

Ms. Schakowsky. Except that I am asking about the penalties then, not the monitoring, the penalties, no longer imposing financial penalties for each day.

Dr. Goodrich. So we do still impose financial penalties for each day, so per day penalties depending upon the circumstance. And the number of those penalties has actually risen over the last 4 years. In 2014 we had just over 1,100 per day civil monetary penalties and in 2017 we had almost 2,000 per day.

Ms. Schakowsky. So let me ask you this. Do the nursing home advocates support these changes?

Dr. Goodrich. We have certainly worked with and been transparent about our intents here related to --

Ms. Schakowsky. That is kind of a yes or no.

Dr. Goodrich. I would have to ask the nursing home advocates. We certainly have had discussions with them about

this. We have seen --

Ms. Schakowsky. My understanding is no. Let me also, I want to get to a Human Rights Watch report found that in an average week nursing facilities in the United States administer powerful anti-psychotropic drugs in over 179,000 people who don't need them. I ask unanimous consent to enter that report into the record.

Mr. Harper. Without objection.

[The information follows:]

**********COMMITTEE INSERT 4**********

Ms. Schakowsky. These drugs are often given without informed consent. This is after a 2011 OIG report that found rampant overuse of these anti-psychotic drugs.

So, Dr. Goodrich, what actions are CMS taking to address the high rate of these drugs and used 7 years after that OIG report?

Dr. Goodrich. So we would completely agree that this has been a very significant quality and safety issue within nursing homes. That is why in 2011 in partnership with a number of stakeholders we launched the National Partnership to Improve Dementia Care in Nursing Homes which was a holistic effort around dementia care, but definitely had a very serious focus around reducing inappropriate use of anti-psychotics in nursing homes.

We have seen over that time period from 2011 to early 2017 a 34 percent reduction in the inappropriate use of anti-psychotics and we are now focusing --

Ms. Schakowsky. So two-thirds still remains.

Dr. Goodrich. So there is still overuse. That is true. And there are particular nursing homes in the country who have not made the kinds of improvements that we would hope. And so we have set a new goal to focus on those facilities that are still overusing to unacceptable extent.

Ms. Schakowsky. Thank you.

Mr. Harper. The gentlewoman yields back. The chair will now recognize the gentlewoman from California, Mrs. Walters, for 5 minutes.

Mrs. Walters. Thank you, Mr. Chairman. Federal regulations enumerate a limited number of circumstances under which a nursing facility or skilled nursing facility may transfer or discharge a resident against their will. Under federal law, a nursing facility or skilled nursing facility must also readmit residents who may temporarily leave for a hospitalization. However, claims that nursing home residents are being dumped or denied readmission appears to be a growing concern.

For example, according to press reports, the California State Long-term Care Ombudsman received more than 1,500 complaints in 2016 alleging that residents have been improperly discharged or evicted from nursing homes in California. This is a 73 percent increase from the number of complaints received since 2011. The Illinois State Ombudsman has stated that such complaints have more than doubled since 2011.

Dr. Goodrich, does CMS view involuntary discharges of nursing home residents or denials of readmission as a significant problem?

Dr. Goodrich. Yes. This is something that we have also heard reports about happening and it is something that we're concerned about absolutely.

Mrs. Walters. When nursing homes residents are involuntarily discharged from or denied readmission to a nursing home after a hospital stay, where do they typically end up and how are they cared for?

Dr. Goodrich. So I think that's variable and that is something that we are trying to explore a little further to understand what's happening on the ground with these residents. So certainly where they end up if that's your question can be quite variable. It can be, you know, with a family member and another facility is often where they will end up going as well.

Mrs. Walters. Are you guys trying to do any sort of analysis on this to find out exactly where they are ending up?

Dr. Goodrich. I'd be happy to get back to you with the answer to the question to how we're taking a look at that. I'm not sure of the specifics.

Mrs. Walters. Did you want to add something?

Ms. Dorrill. We have, we're currently underway on this exact issue. I share your concern and we have a study that will be coming out shortly that will be of interest to you.

Mrs. Walters. Okay, thank you.

Federal law also requires states provide nursing home residents, who allege they were improperly discharged or transferred, with a hearing and, if appropriate, provide for residents a readmission to the nursing home if they prevail. However, it has been alleged that California is failing to enforce its own hearing decisions in instances where decisions have been rendered in favor of residents.

In a 2012 letter to the California Department of Public Health, Center for Healthcare Quality, CMS stated that while it

could not advise California what particular state agency should enforce the hearing decisions, as that is for the states to decide, CMS regulations are clear that the state agency must promptly make corrective actions. CMS reiterated California's obligation to enforce its hearing decisions in a letter sent on August 31st, 2017.

Dr. Goodrich, how does CMS verify that states are fulfilling their legal obligations to adjudicate and enforce hearing decisions related to improper nurse home discharges or transfers?

Dr. Goodrich. So this is a topic with which I'm not terribly familiar of the specifics of the California case, but we'd be very happy to take a look at it and get back to you with responses to that.

Mrs. Walters. Okay, so then I don't know if you can answer these two questions but I will ask you. Does CMS know whether California is meeting its legal obligations to enforce these decisions?

Dr. Goodrich. I'm not personally aware but we will get back to you with that.

Mrs. Walters. Okay, then I have one more. Does CMS know of or have reason to believe other states may be failing to enforce their hearing decisions?

Dr. Goodrich. I think that's something we certainly would be concerned about and would be happy to get back to you with responses.

Mrs. Walters. Okay, if you guys could follow up --

Dr. Goodrich. We will.

Mrs. Walters. -- and get back to the committee on that we would really appreciate it.

Dr. Goodrich. Of course.

Mrs. Walters. Thank you and I yield back the balance of my time.

Mr. Harper. The gentlewoman yields back. I will now recognize the vice chairman of the subcommittee, Mr. Griffith, for the purposes of a follow-up question.

Mr. Griffith. Yeah, and I think that Ms. Schakowsky and I might be on the same side, we might not be, but it deals with the daily fines and so forth. Because I am aware of a situation, so I am glad you are looking at it so we can get these algorithms where they make sense because you want to punish people for bad acts.

But I am aware of a situation where coffee was spilled. There was an incident. Something should have been said but somehow the fine ended up being between a million and two million dollars. The patient never went to the hospital. No serious injuries. Clearly something needed to be done, but it seemed that maybe the old algorithm was a little out of whack if you end up with a million to two million dollar penalty for spilled coffee and no hospitalization.

Dr. Goodrich. So I'm not familiar with that particular

incident, but I think that is potentially an example where there was again as I mentioned before we weren't always seeing consistent application of the civil monetary penalties in both directions. And so that's why we really have been trying to standardize that.

Mr. Griffith. And I appreciate that and hope that you all get that all worked out, but agree that there ought to be penalties and there ought to be something that the nursing homes can know that this is what we are supposed to do, and if there is a problem the penalty will be something that is equal to or in the vein of what ought to be happening.

Thank you, yield back.

Mr. Harper. The chair will now recognize Ms. Schakowsky for the purposes of a follow-up question.

Ms. Schakowsky. So in terms of CMS enforcement I wondered how you are using these new -- we have been talking somewhat about the payroll staffing data reported by nursing homes to enforce the requirements that each facility have a registered nurse on duty at least 8 hours every day. Let me just state my preference. I mean I think most people who put a person in a nursing home would be shocked that there is not a nurse, a registered nurse 24/7, you know, when they get the bill for the month that there is not a nurse there.

I have a piece of legislation I have introduced, Put a Nurse in a Nursing Home. But I am just wondering how you are following

up on that.

Dr. Goodrich. Absolutely. Thank you for bringing that up. We would agree that the new payroll-based journal system gives us really unprecedented insight into staffing within nursing homes. And as you mentioned, some of the things that we have discovered since we started requiring the reporting of those data is exactly what you mentioned, is that there are some nursing homes that do not have a registered nurse as required by our regulations for 8 hours a day, 7 days a week. And I think even more concerning is that we see fluctuations in some nursing homes, again a minority but it's there, where that those deficiencies in nurse staffing are more common on the weekends than they are on the weekdays. And I can't think of any clinical reason why that should be different on a Saturday than on a Tuesday.

So that is something that we are concerned about and right now we're taking two actions related to that. I will caveat that by saying this is early, we're exploring the data and we're thinking ahead about other ways in which we can use these data better. So number one, one thing we have already done is in the five-star rating system nursing homes that do not have nurse staffing as appropriate for at least 7 days out of a quarter, their star rating goes down to one star and that affects the staffing star rating and that affects that overall star rating as well.

We are also looking at ways in which we could incorporate the findings that I just mentioned about the fluctuations and the lack of nursing as required by regulation further into the star rating system. The second thing that we're doing is that we are embedding the data, the staffing data into our survey software which will then allow the state surveyors when they go onsite to do their investigations to have that information around staffing for that nursing home that they are in so that they can look for quality issues that may be related to staffing based upon the data they have right there in their hand.

So those are two ways in which we're, for now, initially using these data, but we'll continue to explore other ways.

Ms. Schakowsky. Okay, and any of the other two witnesses want to say anything on this topic? I don't know.

Ms. Dorrill. I just wanted to say that we have work underway now on the payroll-based journal and we plan to look at the accuracy of the data and CMS' use of it at this early implementation.

Ms. Schakowsky. Okay. I would really like to see that after you complete your investigation of that issue. So good, thank you very much. I yield back.

Mr. Harper. The chair will now recognize the gentleman, in celebration of his birthday, the gentleman from Georgia, Mr. Carter.

Mr. Carter. Thank you, Mr. Chairman. I appreciate you

sharing that with everyone. And I do appreciate it very much.

Mr. Harper. We didn't ask what year.

Mr. Carter. You can't thank me for that as well, yeah.

Well, thank all of you for being here. Full disclosure, I am currently the only pharmacist serving in Congress. Not only am I a pharmacist, but I was also a consultant pharmacist and my expertise and my career was spent in institutional pharmacy in nursing homes. I have gone through federal inspections, state inspections, so this is something that I am very familiar with.

And I have to tell you I was blessed to be in a number of good nursing homes that provided quality care that really cared about the patients and sometimes I could be frustrated by some of the regulations. And I just want to encourage you, a couple of things. First of all, you know, it is important and it is important to have a registered nurse 8 hours a day. It is important to make sure that rules and regulations are followed, but sometimes we get caught up in the cookie cutter approach that one size fits all.

And I just want to encourage you and I say that because I have seen it firsthand. I have seen how nursing homes struggle and they struggle to find good quality help. They don't pay very high, they can't afford to. It is difficult at times. That is no excuse, you still have to have quality care and as I say I was very blessed to be in facilities that provided quality care.

I think that you have -- I am sorry I had another hearing,

but we have already talked about the payroll-based journal and about the fact that salaried employees, and trust me, I have seen a salaried, a DNS who has, you know, is registered as 40 hours seeing a more 60 or 80 hours a week. So that is kind of a misnomer and I hope you take that into consideration.

And then whenever, you know, you are talking about a 30-minute lunch break, I have seen them, you know, take 5 minutes to cram something in their mouth and go on and continue on. I have also seen it as you well know, and I know I am the preacher preaching to the choir here, but nursing homes can fall apart quickly. I have been in a nursing home in the morning and it was, you know, in top shape and then by the afternoon and just because of the patient population it can really fall apart very quickly. But anyway, having said that I will tell you that I am concerned particularly the federal inspectors as it relates to the state inspectors. I have seen the state inspectors sometimes try to do too much because the federal inspectors are following them. Generally what happens is that you would always know if the fire inspector came and then probably the surveyors, the state surveyors were coming next because the fire inspector would always come first and then the state surveyors would come.

And the federal surveyors would come after the state surveyors in order to see how well the state surveyors had done and sometimes I felt like they were putting undue pressure on some of the state inspectors. Not that they didn't need it at

times, they did, and it is important. It is important to have the checks and balances in that and I understand that.

I wanted to ask you and I will ask Dr. Goodrich, you, this question about some of the potential complexity for providers that have that the regulations. As I understand it, there has been a temporary moratorium placed on some of the 194 regulations as a result of the stakeholder feedback. Just to clarify, how many of the 194 regulations had this moratorium placed on them?

Dr. Goodrich. Eight.

Mr. Carter. Eight of them. And out of those eight did any of those have to do with neglect or with abuse?

Dr. Goodrich. They did not.

Mr. Carter. They did not, okay. Good, they should not and I appreciate that. And, finally, do facilities still have to enforce these eight regulations and have a plan in place to fix them if they are noncompliant?

Dr. Goodrich. Absolutely. That's our expectation, yes.

Mr. Carter. That is your expectation, good. Again you know, I have seen the burden that can be placed on these facilities and again no one is accepting and I am certainly not advocating that they shouldn't have quality care. This is a very feeble, if you will, population that needs this help. But I just want to make sure we have balance here. I want you to understand that I have worked side by side with these people in the nursing homes and they are good people who truly -- for the most part.

Now like every profession you have bad actors and you have to get rid of those bad actors and to a certain extent, to a large extent that is your responsibility and the responsibility of the state surveyors. We need to get those bad actors out. They need to be brought to justice, if you will. But for the most part, I want you -- I just feel like I need to express to you the true quality work that many of these facilities provide and that many of these employees provide. And, Mr. Chairman, I will yield.

Mr. Harper. The gentleman yields back. The chair will now recognize the gentleman from Florida, Mr. Billirakis, for 5 minutes.

Mr. Bilirakis. Thank you, Mr. Chairman. I appreciate it. Thanks for holding this hearing, so very important.

As you know, Mr. Chairman, last year we had Irma that hit Florida. The many hardworking staff of our nursing homes and assisted living facilities prepared for the hurricane, 862 facilities evacuated, over 2,000 facilities lost power in the state of Florida. They were tested by the storm and the vast majority passed. Again those folks were doing the Lord's work and we do appreciate them so very much.

Yet, in every group there are bad actors as my colleague just said. We had the Rehabilitation Center at Hollywood Hills fail to take the proper measures to protect their residents and as a result 12 people died from heat exposure despite having a hospital across the street from the facility. These deaths were

100 percent preventable.

One of the concerns that have is how many facilities are not in compliance with the emergency rule. Dr. Goodrich, I believe that CMS began compliance surveys last year. That is my understanding. Do we know how many facilities are currently not in compliance with the emergency rule? That is my first question.

Dr. Goodrich. Certainly. So we are about 75 percent of the way through surveying all facilities nationally for the emergency preparedness requirements. We will have completed surveys for a hundred percent of facilities by February of 2019. While we are finding that the majority of facilities are in compliance or come into compliance quickly, we have had some citations for noncompliance that are intended to swiftly bring these facilities into compliance. So we have had about 2,300 facilities or so, so far, be cited for noncompliance that then would have to implement a corrective action plan in order to come into compliance.

Mr. Bilirakis. So 2,300 out of how many?

Dr. Goodrich. There's a total of about 15,600 nursing homes but again they haven't all been surveyed yet.

Mr. Bilirakis. Right, so but the majority of them have been surveyed.

Dr. Goodrich. Seventy five percent about.

Mr. Bilirakis. Okay, thank you. The rehab center had their

provider agreement terminated. This is the one that I was speaking of in Hollywood, Florida. It was terminated by CMS. Despite this, the owner of the rehab center still has an ownership stake in 11 other facilities that participate in the Medicare program. These facilities continue to operate despite the tragedy that occurred last year and the previous allegations that the Department of Justice made against the owner regarding providing unnecessary medical treatment to seniors.

Dr. Goodrich, given your experience at CMS, are you surprised by this that there are so many, he is operating so many other facilities? And yes and is he being monitored? Can you maybe expand on that, please?

Dr. Goodrich. Certainly. So for any Medicare-certified facility of any type they are required to undergo surveys just like nursing homes do, so whatever type of facility an owner may have an ownership interest in. So they have to undergo periodic recertification surveys in the situation of nursing homes, those are annual. And then there's complaint surveys that can take place if somebody files a quality of care complaint.

So any facility no matter what type that is Medicare-certified would have to undergo these surveys as well.

Mr. Bilirakis. Okay, can you maybe get back to me on whether these other 12 facilities that this person owns follow the emergency rule? Can you give me that information? I know you can't, more than likely you don't have it with you now.

Dr. Goodrich. What I do know is that the other facilities owned by this owner have undergone the standard recertification surveys. As it relates specifically to emergency preparedness we will have to get back to you on that.

Mr. Bilirakis. Please get back to me on that. I appreciate it. Again, Doctor, I know the state is trying to pull the rehab center's owners licenses, but I am told it is tied up in the court system at the moment. I know I don't have a lot of time, so can CMS terminate the provider agreements with the various facilities that he has an ownership stake in? Do you have the ability to do that?

Dr. Goodrich. As I understand it, Medicare has the ability to bar an individual from owning other facilities under two circumstances. One is if they have a felony conviction and the second is if they're on the OIG exclusion list.

Mr. Bilirakis. Okay, very good.

Well, thank you, Mr. Chairman. Thanks for allowing me to sit in and thanks for holding this hearing. I appreciate it.

Mr. Harper. The gentleman yields back.

Just a little quick follow-up to you, Ms. Dorrill, and to you, Mr. Dicken. Both HHS OIG and GAO have found situations where these allegations of abuse or neglect or substandard care they have been reported but state survey agencies failed to investigate those claims in a timely manner. CMS reserves immediate jeopardy classifications for situations that have caused or are likely

to cause a serious injury, harm, or death to a resident and require such a claim to be investigated within 2 days.

So, Ms. Dorrill and Mr. Dicken, when state survey agencies fail to conduct those timely investigations especially in cases of immediate jeopardy, does that place nursing home residents at greater risk?

Mr. Dicken. Certainly as we've looked at the complaint investigation processes we've seen that states have sometimes been challenged to meet timeframes better at the immediate jeopardy types of issues that you raise. We did see, however, that as states are not timely it's much more difficult for states to be able to substantiate allegations and there are higher substantiation when they are meeting timely frameworks. So it is important to have a timely and complete complaint investigation.

Mr. Harper. All right. Well, let me follow up on that. So does this failure also potentially allow facilities which may have in fact harmed a resident to go unpunished and perhaps give a false impression that they are providing a better standard of care than they actually are?

Mr. Dicken. Well, certainly to the extent that the complaints are not investigated or not investigated in a timely manner that as you know can make it hard to substantiate. Certainly there are other processes that can go in and identify that as part of the standard survey process, but that is a real

concern that if they are not being substantiated and because of not timely reviews.

Mr. Harper. Thank you.

Ms. Dorrill, anything you would like to add to that?

Ms. Dorrill. Just to reiterate how important timeliness is in terms of substantiation. We did find that there were only a handful of states who had substantial problems with that to the extent that that's helpful.

Mr. Harper. I want to thank each of you for being here. Our concern is the care and well-being of the residents of any of these facilities. They are the loved ones of many families that care greatly about what happens. You have a great responsibility. We thank you for being here today.

I also want to remind members that they have 10 business days to submit questions for the record, and should you receive any of those as witnesses from today we would appreciate your response as promptly as possible to that. With that the subcommittee is adjourned.

[Whereupon, at 12:00 p.m., the subcommittee was adjourned.]