STATEMENT OF

KATE GOODRICH, M.D.,

DIRECTOR,

CENTER FOR CLINICAL STANDARDS AND QUALITY, AND

CHIEF MEDICAL OFFICER,

CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

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

BEFORE THE

U. S. HOUSE ENERGY AND COMMERCE COMMITTEE,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

SEPTEMBER 6, 2018

U. S. House Energy and Commerce Committee,
Subcommittee on Oversight and Investigations
"Examining Federal Efforts to Ensure Quality of Care
and Resident Safety in Nursing Homes"
September 6, 2018

Chairman Harper, Ranking Member DeGette, and members of the Subcommittee, thank you for the invitation and the opportunity to discuss efforts at the Centers for Medicare & Medicaid Services (CMS) to oversee nursing homes. Resident safety is our top priority. It is the duty of every nursing home serving Medicare and Medicaid residents to keep its residents safe and provide high quality care.

Monitoring patient safety and quality of care in nursing homes serving Medicare and Medicaid beneficiaries requires coordinated efforts between the federal government and the states. To qualify for payment for services to beneficiaries, a nursing home must be enrolled in and certified by CMS as a skilled nursing facility under the Medicare program or a nursing facility under the Medicaid program. States play a critical role in helping CMS survey for facility compliance with both federal and state requirements, such as licensure.

To become certified as a Medicare and Medicaid participating provider of services, a nursing home must meet federal statutory and regulatory requirements which include a list of specific requirements for participation pertaining to health, safety and quality.[1] Compliance with these requirements for participation is verified through unannounced on-site surveys. Nursing homes must remain in substantial compliance with these requirements, as well as state law, to continue as a Medicare or Medicaid participating provider. Our efforts are informed and improved by the work of the Government Accountability Office (GAO) and the Department of Health and Human Services Office of Inspector General (HHS-OIG), and we greatly appreciate their recommendations and ongoing assistance to ensure resident safety and facility compliance.

In addition to these quality and safety oversight efforts, CMS has made improving the quality of care provided in nursing homes and providing information to consumers about nursing home

[1] Sections 1819 and 1919 of the Social Security Act and 42 C.F.R. Parts 483 and 489.

quality a top priority. For example, in response to quality and safety concerns related to the use of antipsychotic medications among a growing number of residents with dementia, CMS launched the National Partnership to Improve Dementia Care in Nursing Homes, which has worked to optimize the quality of care and quality of life for residents in America's nursing homes by improving care for all residents, especially those with dementia, by reducing the use of antipsychotic medications and enhancing the use of nonpharmacologic approaches and person-centered dementia care practices. The CMS Nursing Home Compare[2] website provides detailed information for comparison of nursing homes and features a Five-Star Quality Rating System to help consumers, their families, and caregivers compare nursing homes more easily. At the direction of Administrator Seema Verma, CMS has been working tirelessly to evaluate and streamline regulations and operations with the goal to reduce unnecessary burden, increase efficiencies, and improve the customer experience for nursing facilities so that the priority is the care of the patient.

Quality and Safety Oversight

CMS works with state survey agencies in each of the 50 states, the District of Columbia, Puerto Rico, and other U.S. territories to perform surveys of providers and suppliers. For nursing homes, state survey agencies inspect these providers for compliance with Medicare and Medicaid health and safety standards related to both delivery and monitoring of care, as well as Life Safety Code requirements intended to protect residents by providing a reasonable degree of safety from fire. The states also take intake of complaints and conduct investigations accordingly.

Facilities must meet state licensure requirements, in addition to CMS statutory and regulatory requirements, to be certified as a Medicare and Medicaid provider. The state survey agency, working on behalf of CMS, is usually the same agency responsible for both state licensure and Federal surveys and oversight. Therefore, these on-site surveys are often performed by the same state team at the same time, with the findings entered into two separate survey reports: one for state licensure purposes and one for Medicare and Medicaid compliance purposes. Utilizing the expertise of state officials to perform surveys means that state agencies and officials have up-to-

[2] Available at: https://www.medicare.gov/nursinghomecompare/search.html

date information on health and safety risks at facilities, and, as appropriate, can take direct action against facilities through state licensure sanction as well as recommend federal enforcement actions and remedies in response to deficiencies with health and safety requirements.

CMS is always looking for ways to improve our quality and safety oversight efforts to safeguard nursing home residents. CMS recently updated and improved the emergency preparedness requirements for nursing homes and other providers participating in Medicare and Medicaid.[3] For example, we clarified that certified nursing homes must have emergency electrical power systems for lighting entrances and doorways and maintaining fire detection, alarm, extinguishing systems as well as life support systems, must have emergency and stand-by-power systems and have a plan for ensuring these systems are operational during an emergency, and introduced additional testing requirements for these emergency and stand-by-power systems. In addition, we required facilities to develop an emergency preparedness training and testing program for new and existing staff, contracted service providers, and volunteers, as well as periodic refresher training. Facilities were required to comply with the new emergency preparedness on November 15, 2016, and surveys to evaluate compliance with the new requirements began on November 15, 2017.

CMS also made revisions to the other nursing home requirements in late 2016. These changes reflect the first comprehensive review and update of the regulations since 1991. These updated regulations reflect the substantial advances that have been made over the past several years in theory and practice of service delivery and safety and address important public health priorities such as combatting multi-drug resistant organisms among this vulnerable population. The changes made to the regulations include ensuring nursing home staff are properly trained on caring for residents with dementia and in preventing elder abuse, facilities take into consideration the health of residents when making decisions on the kinds and level of staffing a facility needs, staff have the right skills and competencies to provide person-centered care, resident's care plans take into consideration goals of cares and preferences, improvements to care planning including discharge planning, allowing dieticians and therapy providers the authority to write orders when

[3] https://www.federalregister.gov/documents/2016/09/16/2016-21404/medicare-and-medicaid-programs-emergency-preparedness-requirements-for-medicare-and-medicaid

delegated by a physician and state licensing laws allow, and updating the infection and control program including requiring an infection prevention and control officer and an antibiotic stewardship program. These revisions are also an integral part of our efforts to achieve broad improvements both in the quality of health care furnished through federal programs, and in patient safety, while at the same time reducing procedural burdens on providers.

Given the number of revised and new requirements in this rule, CMS is implementing it in three phases. The three phases were determined based on complexity of the revisions and the work necessary to revise the interpretive guidance and survey process based on the revisions. The requirements under Phase 1 implemented in November 2016, included those that did not impose additional requirements on facilities or were straightforward to implement. Phase 2 requirements are new requirements and those provisions that required more complex revisions; these were implemented in November 2017. CMS also implemented a revised survey process at this time to strengthen the survey system incorporating these new requirements. On November 24, 2017, CMS announced a temporary moratorium on the imposition of certain enforcement remedies such as civil monetary penalties for eight Phase 2 requirements, because of concerns from stakeholders about the scope and timing of their implementation.[4] CMS is using this 18-month moratorium period to educate nursing homes and providers to ensure they understand the health and safety expectations that will be evaluated through the survey process. However, the Phase 2 temporary moratorium is limited to 8 of 194 requirements and does not include those deficiencies related to abuse or neglect of residents. It also does not pause those enforcement activities that are required by federal law such as termination for immediate jeopardy findings that are not resolved. Compliance with all Phase 2 requirements is still monitored and cited, which is reflected in facilities' survey reports. In addition, all deficiencies are required by federal law to be corrected within 6 months or the facility will be terminated from participating in the Medicare and Medicaid programs.

Nursing homes are required by law to receive a recertification survey on an annual basis. Generally, state survey agencies conduct nursing home recertification surveys every year on

[4] https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-18-04.pdf

behalf of CMS to assess facility compliance. However, complaint surveys can be performed at any time, with the actual timing dependent on the severity of the allegation. The Nursing Home Compare website includes links and other helpful information to help patients and families determine when and how to file a complaint.[5] In addition, nursing homes are required to post similar information on how to file complaints and grievances in their facilities.

When state inspectors identify violations of federal certification requirements, they notify the facility and in serious cases refer the case to CMS for enforcement. In most cases, the facility is required to develop a plan of correction to address identified violations within a time period depending on the scope and severity of the noncompliance violation. Enforcement actions where administrative remedies are imposed are taken against nursing homes that are not in compliance with Federal requirements. The law provides that CMS or the state authority impose one or more remedies when a facility is found to be out of substantial compliance with Federal requirements. When immediate jeopardy to resident health and safety exists (meaning that the facility's noncompliance with one or more requirements has caused, or is likely to cause, serious injury, harm, impairment, or death), a CMS Regional Office or state Medicaid agency must take immediate action to remove the jeopardy and correct the deficiency by either terminating the facility or installing temporary management in as few as two calendar days after the facility receives notice that immediate jeopardy exists. Civil monetary penalties can also be assessed up to approximately $20,000 per day (or per instance) until substantial compliance is achieved for the deficiency identified. For deficiencies that do not constitute immediate jeopardy, remedies could include directed in-service training, denial of payments, or civil monetary penalties. Termination of a facility's Medicare and Medicaid participation is required by law for nursing homes that do not achieve substantial compliance for non-immediate jeopardy deficiencies within six months.

For those nursing homes which have more deficiencies than average, more serious deficiencies, or a pattern of serious deficiencies persisting over a long period of time, CMS may designate the

[5] https://www.medicare.gov/NursingHomeCompare/Resources/State-Websites.html

nursing home as a Special Focus Facility [6], which requires the nursing home to be visited in person by survey teams twice as frequently as other nursing homes. CMS has strengthened the Special Focus Facility, or SFF, program over the past several years to ensure that homes either improve so that they can graduate from the program or they are terminated from Medicare/Medicaid participation. The longer the problems persist, the more stringent we are in the enforcement actions that will be taken. The objective of all remedies is to incentivize swift and sustained compliance in order to protect resident health and safety. Within about 18-24 months after a facility is identified by CMS as an SFF nursing home, we expect that the facility would improve and graduate from this program, be terminated from the Medicare or Medicaid program, or show progress but continue as an SFF nursing home for some additional time.

CMS is dedicated to maintaining an enforcement system that is centered on promoting high quality resident-centered health and safety for nursing home residents. It is always our goal to ensure patient access to care while making sure patients are safe and appropriately cared for. CMS collaborates with state partners to educate nursing homes regarding our requirements, making sure they have the information they need to address any violations found during a survey. It is our hope that our efforts will help facilities come back into compliance, as well as prevent future noncompliance, without requiring termination from the Medicare and Medicaid programs. Nevertheless, we will terminate facilities that do not appropriately correct deficiencies because it is our obligation to ensure all nursing home facilities are safe and can meet resident needs.

CMS also leads the National Nursing Home Quality Care Collaborative with the Quality Innovation Network-Quality Improvement Organizations. The Collaborative launched in April 2015 with the mission to improve care for the 1.4 million nursing home residents across the country. The Collaborative works to rapidly spread the practices of high performing nursing homes to every nursing home in the country with the aim of ensuring that every nursing home resident receives the highest quality of care. Specifically, the Collaborative strives to instill quality and performance improvement practices, eliminate healthcare-acquired conditions, and

[6] For more information see: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/downloads/SFFList.pdf

dramatically improve resident satisfaction by focusing on the systems that impact quality, such as staffing, operations, communication, leadership, compliance, clinical models, quality of life indicators, and specific, clinical outcomes. Every state in the country has a significant percentage of nursing homes that voluntarily participate in this collaborative.

CMS also works with GAO and HHS-OIG to identify problems and implement recommendations that can improve our oversight of nursing home facilities. For example, GAO recommended that CMS develop timeframes and milestones for the development and implementation of a standardized survey methodology across all states.[7] CMS has implemented a new computer-based standardized survey process for nursing homes that is resident-centered which emphasizes evidence of potential quality of care issues and concerns identified through resident observation and interviews. This new survey process provides additional standardization and structure to help ensure consistency between surveyors while allowing surveyors the autonomy to make decisions based on their expertise and judgment.

Addressing Suspected Abuse and Neglect in Nursing Homes

Abuse and mistreatment of nursing home residents is never permitted, and CMS takes any allegation of these types of incidents very seriously. CMS requires nursing homes to report allegations of abuse and neglect immediately to their State Survey Agencies. When we learn a nursing home failed to report or investigate incidents of abuse, CMS takes immediate action against the nursing home. For example, in 2017, when a state surveyor found that a nursing home did not properly investigate or prevent additional abuse involving 8 residents, the nursing home was cited with noncompliance at the most serious immediate jeopardy level and was assessed a civil monetary penalty totaling approximately $347,000. In addition to issuing civil monetary penalties, CMS can deny payments or terminate a facility's Medicare and Medicaid participation agreements when appropriate. Since November 2017, CMS has issued noncompliance deficiency citations for nursing homes for failure to report or investigate allegations of abuse or neglect 2,323 times.

[7] See: https://www.gao.gov/assets/680/673480.pdf

Section 1150B of the Social Security Act requires covered individuals such as employees, contractors and operators of federally funded nursing homes to report immediately to the HHS Secretary and local law enforcement any reasonable suspicion of a crime (as defined by local law enforcement) committed against a resident of a nursing home. CMS has taken a number of steps to implement the reporting requirements under section 1150B of the Social Security Act since enactment of this provision. CMS has issued memoranda, developed education tools for nursing facility staff, and provided outreach to State Survey Agencies regarding these requirements. Specifically, in 2011, CMS issued memoranda[8] informing nursing homes of these new reporting requirements and the process for dealing with reporting of suspected crimes. In 2012, we developed a toolkit[9] that addressed abuse and the section 1150B reporting requirements and mailed this training program to all nursing facilities in the country. In 2016, section 1150B requirements were formally incorporated into federal regulations through notice and comment rulemaking. In 2017, CMS published sub-regulatory guidance that provided further clarification these requirements. [10] Specifically, this guidance clarifies terms in the regulation such as "reasonable suspicion of a crime" and describes the process the State Survey Agency uses to evaluate compliance with the requirements. CMS also released training information related to the reporting requirements, including a video that trains surveyors and the public on the minimum facility requirements in preventing abuse and neglect of nursing home residents. The state surveyors began surveying nursing facilities specifically regarding the 1150B requirements on November 28, 2017.

Additionally, CMS has been coordinating with HHS-OIG regarding the formal delegation of the authority to impose a civil monetary penalty against individuals covered under section 1150B and the facility for retaliation against such individuals, and the authority to permissively exclude those same individuals, as well as the noncompliant facilities, from any federal health care programs. The OIG currently has similar enforcement authorities under sections 1128 and 1128A of the Social Security Act.

[8] https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/SCLetter11_30.pdf
[9] https://surveyortraining.cms.hhs.gov/pubs/ClassInformation.aspx?cid=0CMSHANDINHAND
[10] https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html

We anticipate that this formal delegation will be completed shortly. However, irrespective of the formal delegation, because a nursing home's obligations under section 1150B have been incorporated into program participation requirements, if an instance of noncompliance with these requirements by facilities were to be identified, enforcement sanctions such as civil monetary penalties, denial of payments, and termination of a facility's Medicare and Medicaid participation agreements, can be imposed under CMS's existing enforcement authority under sections 1819(h) and 1919(h) of the Act. CMS will continue to work with the HHS-OIG to enhance our ability to hold covered individuals accountable for reporting in addition to facilities as a whole and intend to issue regulations regarding enforcement following the formal delegation.

While CMS is not a law enforcement agency, we take cases of patient neglect and abuse very seriously and we work with state agencies, law enforcement, nursing home leadership and staff to ensure this vulnerable population is properly cared for and that all viable or alleged instances involving abuse or neglect are fully investigated and resolved. We are always looking to improve our programs and find better ways to identify, track, and, most importantly, prevent cases of neglect or abuse. To improve our current enforcement efforts, we will continue to work in partnership with GAO, HHS OIG, Congress, Regional Offices, states, consumer advocates, national associations, and other stakeholders.

National Partnership to Improve Dementia Care in Nursing Homes

Through our the National Partnership to Improve Dementia Care in Nursing Homes[11] (National Partnership), CMS has partnered with federal and state agencies, nursing homes, other providers, advocacy groups, and caregivers to improve comprehensive dementia care. CMS and our partners are committed to finding new ways to implement practices that enhance the quality of life for people with dementia, protect them from substandard care and promote goal-directed, person-centered care for every nursing home resident. The Partnership promotes a multidimensional approach that includes public reporting, state-based coalitions, research, training, and revised surveyor guidance. While the initial focus of the partnership was on

[11] https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/National-Partnership-to-Improve-Dementia-Care-in-Nursing-Homes.html

reducing the use of antipsychotic medications, the larger mission is to enhance the use of nonpharmacologic approaches and person-centered dementia care practices.

Since the launch of the National Partnership, significant reductions in the prevalence of antipsychotic medication use in long-stay nursing home residents have been documented. Between the end of 2011 and the end of quarter one of 2017, the national prevalence of antipsychotic use in long-stay nursing home residents was reduced by 34.1 percent, decreasing from 23.9 percent to 15.7 percent nationwide. All 50 states showed improvement with some states showing much more improvement than others. The National Partnership continues to work with state coalitions and nursing homes to reduce that rate even further. In October 2017, CMS announced a new national goal, involving a 15 percent reduction of antipsychotic medication use by the end of 2019[12] for long-stay residents in those homes with currently limited reduction rates. Our progress to date indicates that we are about half-way towards meeting that 15 percent goal. This goal builds on the progress made to date and expresses the Partnership's commitment to continue this important effort. We are continuing to look for opportunities to strengthen both the survey process and enforcement efforts to ensure that nursing homes are focused on non-pharmacologic approaches and residents are not receiving medications that do not have a clinical basis.

Ensuring Quality of Care by Putting Patients Over Paperwork

In addition to our monitoring and oversight of facilities, our Agency-wide efforts to return patients to the center of care by incentivizing improved quality and reducing provider burden play a critical, complementary role to our commitment to safeguarding the health of nursing home residents. Through our Patients Over Paperwork initiative[13], CMS is reducing provider burden and allowing clinicians to spend more time with their patients – this is particularly important in a nursing home setting where residents have more complex care needs, and care decisions are often directed by family members. Reducing provider burden can also lower

[12] https://www.cms.gov/newsroom/fact-sheets/data-show-national-partnership-improve-dementia-care-achieves-goals-reduce-unnecessary-antipsychotic
[13] https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/PatientsOverPaperwork.html

administrative costs, allowing facilities to dedicate their resources to other areas such as patient care.

CMS has been working tirelessly to evaluate and streamline regulations and operations with the goal to reduce unnecessary burden, increase efficiencies, and improve the customer experience. We have used several tactics to help us better understand burden related to nursing homes, from formal requests for information from stakeholders to engaging stakeholders directly to provide feedback to CMS on areas of burden. In a May 2017 proposed rule,[14] we stated that we are currently reviewing the nursing home requirements to balance the need to maintain quality of care while reducing procedural burdens on facilities. Specifically we noted that we are reviewing the requirements for obsolete or redundant provisions, areas where processes can be streamlined to reduce burden and cost, or other areas of possible elimination. We asked stakeholders for feedback in areas of burden placed by the revisions to the nursing home requirements and the potential impact of resident care and outcomes. We are considering potential changes to the requirements based on the feedback received.

In the Fiscal Year 2019 Skilled Nursing Facility Prospective Payment System Final Rule, CMS is moving towards a new patient-driven case-mix model system in Medicare to pay for services to residents in skilled nursing facilities. The new Patient-Driven Payment Model is designed to improve the incentives to treat the needs of the whole patient, instead of focusing on the volume of services the patient receives, which requires substantial paperwork to track over time. The Patient-Driven Payment Model simplifies complicated paperwork requirements for performing patient assessments by significantly reducing reporting burden (approximately $2.0 billion over 10 years), helping to create greater contact between health care professionals and their patients. This improved case-mix classification system moves Medicare towards a more value-based, unified post-acute care payment system that puts unique care needs of patients first while also significantly reducing administrative burden.

https://www.gpo.gov/fdsys/pkg/FR-2017-05-04/pdf/2017-08521.pdf

On September 7, 2017, CMS released a facility assessment tool[15] that helps a nursing home determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. The intent of the facility assessment is for the facility to evaluate its resident population and identify the resources needed to provide the necessary person-centered care and services the residents require. The tool may also be used by facilities to make decisions about direct care staff needs as well as capabilities to provide services to residents.

Promoting Transparency, Rewarding Quality, and Encouraging Competition

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

In recent years, we have undertaken a number of initiatives to promote higher quality and more efficient health care for Medicare beneficiaries. These initiatives include Skilled Nursing Facility Quality Reporting Program and Skilled Nursing Facility Value-Based Purchasing (VBP) Program. The overarching goal of these initiatives is to transform Medicare from a passive payer of claims to an active purchaser of quality health care for its beneficiaries.

The Skilled Nursing Facility Quality Reporting Program is authorized by the Social Security Act and applies to skilled nursing facilities and most swing-bed rural hospitals. The goal of the program is to use standardized quality measures and standardized data to enable interoperability and access to longitudinal information for providers to facilitate coordinated care, improved outcomes, and overall quality comparisons. Measures that are reported under the program include functional status, cognitive status, skin integrity, medication reconciliation, and major falls. In addition, measures on readmissions, discharge to community and Medicare spending per beneficiary are calculated using claims data, so skilled nursing facilities do not have to submit additional data for these measures. Under the program, skilled nursing facilities that fail to submit the required quality data to CMS are subject to a 2 percentage point reduction to the otherwise applicable annual market basket percentage update with respect to that fiscal year.

The implementation of the SNF VBP Program is an important step toward transforming how care is paid for, moving increasingly toward rewarding better value, outcomes, and innovations

[15] https://qioprogram.org/facility-assessment-tool

instead of merely volume. As required by law[16], beginning October 1, 2018, the SNF VBP Program will make positive or negative adjustments to the otherwise applicable payments under the Skilled Nursing Facility Prospective Payment System for services furnished by SNFs based on their performance on the program's readmissions measure. The single claims-based all cause 30-day hospital readmissions measure in the SNF VBP aims to improve individual outcomes through rewarding providers that take steps to limit the readmission of their patients to a hospital. Also as required by law, CMS will make available SNFs' performance under the SNF VBP Program, specifically including each SNF's performance score and the ranking of SNFs for each fiscal year.

Nursing Home Compare Five-Star Quality Rating System

Transparency is an important part of CMS's patient safety work and CMS is committed to making sure that patients and their families have the information they need to support their health care decisions for LTC facilities. CMS first created the Nursing Home Compare website in 1998 and has regularly increased the amount of information available to beneficiaries and their families about the quality of care in nursing homes participating in the Medicare and Medicaid programs.

CMS bases the five-star ratings of the Nursing Home Five Star Quality Rating System on an algorithm that calculates a composite view of nursing homes from three measures: results from their health inspections; performance on certain quality measures; and their staffing levels. CMS's Nursing Home Compare Website contains information for more than 15,000 Medicare and Medicaid nursing homes around the country. The website also includes detailed reports on facility health inspections, life safety code inspections and any identified noncompliance deficiency citations.

CMS has continually made improvements to Nursing Home Compare and the Five Star Quality Rating System to enhance and strengthen the comparison tool to provide the most accurate information to beneficiaries and their families. Throughout the years, CMS has added information to Nursing Home Compare, including information on facility ownership, federal administrative sanctions against nursing homes, and the full text of the nursing home health

[16] Section 1888(h) of the Social Security Act.

inspection reports. CMS implemented Nursing Home Compare 3.0 to strengthen and expand the Five Star Quality Rating System by adding quality measures, raising nursing home performance expectations, adjusting the methods for establishing staffing ratings, and expanding targeted surveys. In 2016, CMS expanded the number of quality measures included in Nursing Home Compare and the Five Star Quality Rating System. In April 2018, we replaced the data source for staffing information submitted by facilities through the Payroll-Based Journal system which improves the accuracy of the staffing information on Nursing Home Compare. CMS continues to work to improve Nursing Home Compare and the Five Star Quality Rating System. For example, in October 2018, we will be adding a measure of hospitalizations among long-stay residents as part of our continued efforts to improve quality and reduce costs.

Tracking Nursing Home Staffing Data

CMS has long identified staffing as one of the vital components of a nursing home's ability to provide quality care. Current law requires facilities to electronically submit direct care staffing information (including agency and contract staff) based on payroll and other auditable data. In 2015, CMS developed the Payroll-Based Journal system, which allows all facilities to submit their staffing data each quarter. The data, when combined with census information, is then used to calculate the level of staff in each nursing home. Last April, CMS began using the Payroll-Based Journal data to post staffing information on the Nursing Home Compare tool. This new staffing information is calculated using the number of hours facility staff are paid to work each day in a quarter, instead of the previous method of calculating staffing information using the total number of hours facility staff work over a two-week period. Also, unlike the previous data source, the new data are auditable back to payroll and other verifiable sources. These data provide unprecedented insight into how facilities are actually staffed, which can be used to analyze how facilities' staffing relates to quality and outcomes. In the future, we will also use this data to report on employee turnover and tenure, which also impacts the quality of care delivered.

While the new data warrants additional scrutiny and actions to ensure its accuracy and usefulness to consumers, we believe it will ultimately lead to improved staffing and result in better quality and care for nursing home residents. Already, the new data has helped us identify issues, such as

significant variations in staffing between weekdays and weekends, and days with no registered nurse reported onsite. We are deeply concerned about these issues and are working with nursing homes to address them. For example, facilities who report seven or more days with no registered nurse hours are now assigned a one-star staffing quality rating. We are also planning to use the Payroll-Based Journal data to inform surveyors' investigations to help determine if staffing is an underlying cause of any quality issues. Furthermore, since the start of the program, we have been providing individualized feedback to each facility about their staffing data for them to use to improve the accuracy of future submissions. We will continue to accumulate and analyze the data to ensure that nursing homes are staffing their facilities appropriately in order to provide quality care to residents.

Moving Forward

Resident safety is our top priority in nursing homes that participate in the Medicare and Medicaid programs. We expect every nursing home to keep its residents safe and provide high quality care. CMS remains diligent in its duties to monitor nursing homes participating in Medicare and Medicaid 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 health care.