STATEMENT OF

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ON

"AN ABIDING COMMITMENT TO THOSE WHO SERVED: EXAMINING VETERANS' ACCESS TO LONG TERM CARE."

BEFORE THE

U.S. SENATE COMMITTEE ON VETERANS' AFFAIRS

JUNE 7, 2023

Statement of Jonathan Blum on
"An Abiding Commitment to Those Who Served: Examining Veterans' Access to Long Term Care."
U.S. Senate Committee on Veterans' Affairs
June 7, 2023

Chairman Tester, Ranking Member Moran, and Members of the Committee, thank you for the opportunity to provide an update on the Centers for Medicare & Medicaid Services' (CMS) efforts to strengthen our nation's nursing homes

Over the past several years, the COVID-19 Public Health Emergency (PHE) highlighted and exacerbated the long-standing challenges experienced in many nursing homes, creating an urgent need to address these issues for the well-being of all individuals, including many Veterans, residing in our nation's federally certified nursing homes and the workers who care for them. COVID-19 outbreaks in nursing homes led to exceedingly high rates of infection, morbidity, and mortality. The vulnerable nature of the nursing home population, combined with the inherent risks of congregate living in a health care setting, required aggressive efforts to limit COVID-19 exposure and to prevent the spread of COVID-19 within nursing homes. Ultimately, however, an unacceptable number of Americans living and working in nursing homes lost their lives over the course of the pandemic. The severity of this tragedy demands a bold response, like that underway through the Biden-Harris Administration's initiative to improve safety and quality in the nation's nursing homes.

Tens of billions of federal taxpayer dollars flow to nursing homes each year – and we are committed to ensuring taxpayer dollars go toward the safe, adequate, and respectful care residents deserve. Over the last few years, CMS has been intently focused on supporting nursing

homes, residents and families, and workers through the pandemic. Now that the COVID-19 PHE has ended, these lessons learned are playing an important role in informing our efforts around nursing home quality and staffing moving forward. Our policies must both increase access to care in all parts of the country and dramatically improve quality of care, especially among our lowest performing facilities.

Today, we anticipate that our nursing homes are better able to control future infection outbreaks, maintain full operations, and provide more respectful care environments as a result of the lessons learned during the COVID-19 pandemic. However, we recognize that more must be done to transform nursing homes to become even safer and higher-quality facilities for the entire country. As a result, in 2022, President Biden announced a historic initiative to improve the quality of care in nursing homes.[1] Since the announcement, CMS has focused on advancing those elements where we have full regulatory authority to implement, such as making ownership data more transparent and improving our survey and certification processes. We are working towards establishing a minimum staffing requirement in nursing home facilities to ensure that basic health and safety requirements are met. And we are working with the Congress to ensure that we have the necessary resources to fulfill our survey and certification requirements. The President's initiative recognizes that no one policy or regulation will ensure the sustained quality and access to care improvements that must be made, but we are committed to taking decisive actions to improve the quality of care these individuals receive.

[1] "FACT SHEET: Protecting Seniors by Improving Safety and Quality of Care in the Nation's Nursing Homes." White House https://www.whitehouse.gov/briefing-room/statements-releases/2022/02/28/fact-sheet-protecting-seniors-and-people-with-disabilities-by-improving-safety-and-quality-of-care-in-the-nations-nursing-homes/

CMS's Commitment to Improving Nursing Home Quality

Nursing home oversight is one of CMS's most important tasks, and resident safety is our top priority. CMS takes seriously our responsibility to ensure that residents of long-term care facilities, and their families, are treated with the respect and dignity they deserve. It is critical to remember that for these residents, who comprise one of the most vulnerable populations in the country, nursing homes are not just a health care facility – they are their home. It is the duty of every nursing home serving Medicare and Medicaid residents to keep them safe and provide high quality care. State Veterans Homes, which provide nursing home, domiciliary, or adult day care and are owned, operated and managed by state governments, and any other long-term care facilities serving Veterans that accept Medicare and Medicaid payments, must follow all of the same Conditions of Participation as any other nursing home.

Nursing Home Survey and Certification and Enforcement

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 pertaining to health, safety, and quality.[2] Compliance with these requirements for participation is verified through unannounced on-site surveys. CMS works with state survey agencies (SSAs) in each of the 50 states, the District of Columbia, Puerto Rico, and other U.S. territories to perform surveys of providers and suppliers, including nursing homes. Utilizing the expertise of state officials to perform surveys means that state agencies and officials have up-to-date information on health and safety risks at facilities, and, as appropriate, can take direct action

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

against facilities through state licensure sanction. They can also recommend federal enforcement actions and remedies in response to deficiencies with health and safety requirements.

When state inspectors identify violations of federal certification requirements, 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 violation. Enforcement actions are taken against nursing homes when certain types of noncompliance are found, such as when residents are harmed, or are in immediate jeopardy of serious harm. 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), immediate action must be taken to remove the jeopardy and correct the deficiency. Civil monetary penalties can also be assessed up to approximately $22,000 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. President Biden has called on Congress to raise the dollar limit on per-instance financial penalties levied on poor-performing facilities to $1,000,000 to increase deterrence.

Strengthening the Nursing Home Special Focus Facility Program

Over the years, CMS has found that a subset of nursing homes has more problems than other nursing homes (about twice the average number of deficiencies), more serious problems than

most other nursing homes (including harm or injury experienced by residents), and a pattern of serious problems that have persisted over a long period of time. Although such nursing homes may periodically institute enough improvements to correct problems identified on one inspection, significant problems would often re-surface by the time of the next inspection. Facilities with this type of compliance history rarely address underlying systemic problems that give rise to repeated cycles of serious deficiencies, which pose risks to residents' health and safety.

To address this problem, CMS operates the Special Focus Facility (SFF) program.[3] Since its inception, the SFF Program has identified the poorest-performing nursing homes in the country for increased scrutiny in order to ensure rapid and sustained improvements in the quality of care they deliver. These facilities continue to be inspected roughly twice as often as all other nursing homes – no less than once every six months – and face increasingly severe enforcement actions if improvement is not demonstrated. CMS requires that SFF nursing homes be visited in person by survey teams twice as frequently as other nursing homes (about twice per year). Facilities must pass two consecutive positive inspections to complete the SFF Program. Candidates for the SFF Program are identified based on the results from the last three standard health survey cycles and complaint survey performance converted into points based on the number of deficiencies cited and the scope and severity level of those citations. While in the SFF Program, CMS expects facilities to take meaningful actions to address the underlying and systemic issues leading to poor quality and ensure residents' safety.

[3] 1819(f)(8) and 1919(f)(10) of the Social Security Act

In October 2022, CMS announced additional efforts to increase scrutiny and oversight over the country's poorest-performing nursing facilities in an effort to immediately improve the care they deliver. The changes CMS to the SFF Program is implementing are designed to incentivize facilities to quickly improve their quality and safety performance, allow the SFF Program to scrutinize more facilities over time by moving facilities through the SFF Program more quickly, and promote sustainability of facilities' improvements to ensure they do not regress post-program. Specifically, CMS strengthened the requirements for successful completion of the SFF Program; committed to terminating federal funding for facilities that don't improve within about 18-24 months; imposed more severe escalating enforcement remedies for continued noncompliance and little or no demonstrated effort to improve performance; and incentivized sustainable improvements by extending the monitoring period and maintaining readiness to impose progressively severe enforcement actions against nursing homes whose performance declines after graduation from the SFF Program. States must also consider a facility's staffing level in determining which facilities enter the SFF Program. CMS is also increasing technical assistance by increasing its engagement with these poor-performing nursing homes, through direct and immediate outreach by state and CMS officials upon their selection as an SFF, to help them understand how to improve and to access support resources like CMS Quality Improvement Organizations.

Strengthening Nursing Home Staffing to Enhance Quality of Care

Staffing in nursing homes has a substantial impact on the quality of care and outcomes residents experience, and evidence has shown that adequate staffing is closely linked to the quality of care

residents receive.[4] This was particularly evident during the COVID-19 pandemic. In fact, a recent study of one state's nursing homes found that increasing registered nurse staffing by just 20 minutes per resident day was associated with 22 percent fewer confirmed cases of COVID-19 and 26 percent fewer COVID-19 deaths.[5]

CMS has long identified staffing as a vital component of a nursing home's ability to provide quality care, and the COVID-19 pandemic highlighted and exacerbated the long-standing staffing challenges experienced in many facilities, particularly those in rural communities. CMS has used staffing data to more accurately and effectively gauge its impact on quality of care in nursing homes. For more than 10 years, CMS has been posting information on facility staffing measures on the Medicare.gov Care Compare website. Over the last several years, CMS has made several improvements to the information reported, including transitioning to using staffing data that is electronically submitted by facilities through the Payroll-Based Journal (PBJ) system. Under the PBJ program, facility staffing information is submitted each quarter, and is auditable back to payroll and other verifiable sources.

Last year, CMS also improved accountability for staffing by posting weekend staffing and staff turnover information for each Medicare and Medicaid nursing home on the Care Compare website, and CMS now incorporates this information into the Nursing Home Five-Star Quality Rating System, which is used by CMS to rate the quality of care provided by nursing homes.

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[4] "FACT SHEET: Protecting Seniors by Improving Safety and Quality of Care in the Nation's Nursing Homes." White House. https://www.whitehouse.gov/briefing-room/statements-releases/2022/02/28/fact-sheet-protecting-seniors-and-people-with-disabilities-by-improving-safety-and-quality-of-care-in-the-nations-nursing-homes/

[5] "COVID-19 Infections and Deaths among Connecticut Nursing Home Residents: Facility Correlates." *Journal of American Geriatrics Society*. https://agsjournals.onlinelibrary.wiley.com/doi/epdf/10.1111/jgs.16689.

In addition, CMS plans to issue a proposed rule on minimum staffing requirements for public comment this year. CMS launched a multi-faceted approach aimed at determining the minimum level and type of staffing needed to enable safe and quality care in nursing homes. This effort included issuing a Request for Information (RFI) as part of the Fiscal Year 2023 Skilled Nursing Facility Prospective Payment System Proposed Rule[6] and conducting a new study aimed at determining the minimum level and type of staffing needed in nursing homes. We received many comments on the RFI from members of the public identifying themselves as family members or caretakers of residents living in nursing homes. The vast majority of those comments voiced concerns related to residents not receiving adequate care due to chronic understaffing in facilities. Multiple comments stated that residents will go entire shifts without receiving toileting assistance, leading to falls or increased presence of pressure ulcers. Another commenter, whose parents live in a nursing home, noted that they visit their parents on a daily basis to ensure the provision of quality care and reported that staff in the facility have stated that they are overworked and understaffed. The information obtained through the RFI and the staffing study will help inform CMS's rulemaking efforts to update federal minimum staffing requirements in nursing homes in order to foster better outcomes for residents.

It is CMS's goal to consider all perspectives, as well as findings from the staffing study, as we develop future proposed minimum staffing requirements that advance the public's interest of

[6] *"Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2023; Request for Information on Revising the Requirements for Long-Term Care Facilities To Establish Mandatory Minimum Staffing Levels"* (CMS-1765-P) (87 FR 22720): https://www.federalregister.gov/documents/2022/04/15/2022-07906/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities

safe, quality care for residents. CMS is aware of ongoing health care staffing challenges and the impact they have on rural and other underserved communities. CMS intends to issue policies that ensure safe and quality care for residents while also considering the current landscape and challenges that many providers are facing, particularly in rural and underserved areas.

CMS also issued a Center for Medicaid and CHIP Services (CMCS) Informational Bulletin[7] last year, which included information for states about supporting appropriate staffing in nursing homes through the Medicaid program. To ensure nursing homes are adequately resourced and staffed, CMS encouraged states to tie Medicaid payments to quality measures that will improve the safety and quality of care in nursing homes. The bulletin urged states to assess their approach to Medicaid payments to long-term care providers and utilize flexibilities provided under the law in establishing Medicaid base and supplemental payments, as appropriate, to provide adequate, performance-driven nursing facility rates to ultimately achieve better health care outcomes and address longstanding inequities for Medicaid beneficiaries residing in nursing facilities. CMS also encouraged states to continue developing long-range solutions for training and improving staffing and workforce sustainability issues in nursing homes. The bulletin indicated that CMS has approved a number of different staffing improvement incentives in state Medicaid programs and encouraged states to seek out other solutions to training and testing capacity issues in nursing facilities through collaboration with the states' Departments of Public Health that certify Nurse Aide Training and Competency Evaluation Programs to promote funded training opportunity for staff. Medicaid enrollees residing in nursing homes will only experience better

[7] https://www.medicaid.gov/federal-policy-guidance/downloads/cib08222022.pdf

care through collaboration between states, CMS, providers, and other partners, and we look forward to working closely with them on this important effort.

Value-Based Purchasing Program and Quality Reporting and Improvement

CMS also administers two programs – the SNF Value-Based Purchasing (VBP) Program and the SNF Quality Reporting Program (QRP) – which help drive quality improvements in the care that SNFs provide to Medicare beneficiaries. The SNF VBP Program rewards SNFs with incentive payments based on the quality of care they provide. Currently, this is measured by performance on a single measure of hospital readmissions. Beginning with the FY 2026 program year, the Secretary will expand the SNF VBP Program by adding three new measures. In the FY 2023 SNF PPS final rule, CMS finalized important updates to this program, including the addition of measures that will assess SNF performance on infection prevention and management, the rate of successful discharges to the community from a SNF setting, and the total number of nursing hours per resident day. The FY 2024 SNF PPS proposed rule proposes the adoption of additional quality measures, including measures to assess the stability of the staffing within a SNF using nursing staff turnover rates, the hospitalization rate of long-stay residents, and the falls with major injury rates of long-stay residents. To prioritize the achievement of health equity and the reduction of disparities in health outcomes in SNFs, CMS is also proposing the adoption of a Health Equity Adjustment in the SNF VBP Program that rewards SNFs that perform well and whose resident population during the applicable performance period includes at least 20 percent of residents with dual eligibility status.

The SNF QRP establishes SNF quality reporting requirements and operates as a pay-for-reporting program. SNFs that do not meet reporting requirements are subject to a two-percentage-point reduction in their annual market basket percentage increase. CMS is proposing a number of improvements to the SNF QRP as part of the FY 2024 SNF PPS proposed rule, including the adoption of three new measures, removal of three measures, the modification of one measure, and changes to policies such as data completion threshold requirements. Beginning with the FY 2025 SNF QRP program year, CMS is proposing to adopt the Discharge Function Score measure, which evaluates SNF residents' functional status by calculating the percentage of Medicare Part A SNF residents who meet or exceed an expected discharge function score. Beginning with the FY 2026 SNF QRP program year, CMS is proposing to adopt the Core Q: Short Stay Discharge measure, which will calculate the percentage of residents discharged in a 6-month period from a SNF, within 100 days of admission, who are satisfied with their SNF stay based on beneficiaries' responses to a five-item questionnaire about staff, the care received, whether they would recommend the facility to friends and family, and how well their discharge needs were met. The measures and policies for the SNF QRP proposed in the FY 2024 SNF PPS proposed rule support the Administration's plan to improve safety and quality of care in nursing homes.

CMS-directed Quality Improvement Organization Covid-19 Infection Reduction Activities

CMS currently contracts with Quality Improvement Organizations (QIOs) that help providers across the health care spectrum make meaningful quality of care improvements. CMS has ensured that improving nursing home care is a core mission for QIOs. QIOs are furnishing on-demand trainings and information sharing around best practices to nursing homes. The elderly

population were and continue to be disproportionately affected by COVID-19, and were also more likely to be at risk for severe COVID-19 infection, hospitalization, and death from the disease. During the pandemic, CMS deployed the QIOs to provide individualized assistance to nursing homes serving small, rural, and the most vulnerable populations to improve nursing home quality by managing outbreaks and mitigating the spread of COVID-19.

To date, over 12,000 nursing homes received general technical assistance related to infection control challenges including the provision of educational resources and connecting with peer networks. Over 11,000 nursing homes with serious COVID-19 outbreaks received individualized technical assistance from QIOs. This assistance includes managing outbreaks, root cause analysis, making an improvement plan, and tracking and maintaining progress. Over 7,000 nursing homes received individualized hands-on QIO support for vaccine and booster uptake.

Oversight of Inappropriate Antipsychotics Use in Nursing Homes

CMS is committed to reducing the unnecessary use of antipsychotic drugs in nursing homes and holding facilities accountable for failures to comply with federal requirements. In 2012, CMS launched the National Partnership to Improve Dementia Care in Nursing Homes where CMS and its partners have been committed to finding new ways to implement practices that enhance the quality of life for people with dementia, protect them from substandard care, promote goal-directed, person-centered care for every nursing home resident, and increase the use of non-pharmacologic approaches and person-centered dementia care practices. Through this effort, significant reductions in the prevalence of inappropriate antipsychotic medication use in long-stay nursing home residents have been documented, while also maintaining access to these

medications for residents with an appropriate clinical diagnosis. Between 2011 and the fourth quarter of 2021, the national prevalence of antipsychotic medication use among long-stay nursing home residents was reduced by 39.1 percent to 14.5 percent nationwide, with every state showing reduced rates.[8]

However, inappropriate diagnosis and prescribing still occurs in too many nursing homes. In January of this year, CMS announced it is redoubling its oversight efforts to ensure that facilities are not prescribing unnecessary medications or erroneously coding nursing home residents as having schizophrenia,[9] which can mask the facilities' true rate of antipsychotic usage.

All Medicare and Medicaid nursing homes are required to ensure that residents are free from unnecessary medications.[10] On every standard survey and on relevant surveys conducted in response to complaints, surveyors review medical records to confirm that the clinical indication for any prescribed medicine, including antipsychotics and other psychotropics, is thoroughly documented. CMS has implemented specific enforcement remedies – such as denial of payment for new admissions or per-day civil money penalties – for nursing homes that have continued to have high levels of antipsychotic medication use among long-stay nursing home residents.[11]

[8] National Partnership to Improve Dementia Care in Nursing Homes: Antipsychotic Medication Use Data Report (April 2022) https://www.cms.gov/files/document/antipsychotic-medication-use-data-report-2021q4-updated-07292022.pdf.
[9] "Biden-Harris Administration Takes Additional Steps to Strengthen Nursing Home Safety and Transparency" https://www.cms.gov/newsroom/press-releases/biden-harris-administration-takes-additional-steps-strengthen-nursing-home-safety-and-transparency.
[10] 42 CFR 483.45(d).
[11] QSO19-07-NH (cms.gov)

Additionally, in January 2023, CMS began conducting targeted, off-site audits to determine whether nursing homes are accurately assessing and coding individuals with a schizophrenia diagnosis. Nursing home residents erroneously diagnosed with schizophrenia are at risk of poor care and are prescribed inappropriate antipsychotic medications. This action furthers the Administration's objective to improve the accuracy of the quality information that is publicly reported and the Nursing Home Five-Star Quality Rating System on Nursing Home Compare described below. The use of antipsychotic medications among nursing home residents is an indicator of nursing home quality and used in a nursing home's Five-Star rating calculation; however, it excludes residents with a diagnosis of schizophrenia. If an audit identifies that a facility has a pattern of inaccurately coding residents as having schizophrenia, the facility's Five-Star Quality Measure Rating on the Care Compare site will be negatively impacted. For audits that reveal inaccurate coding, CMS will downgrade the facility's Quality Measure ratings to one star, which would drop their overall star rating as well.

Increasing Access to High-Quality Nursing Homes

Medicare Payments to Skilled Nursing Facilities (SNFs)

The Medicare statute prescribes how payment is made for Medicare SNFs. Medicare Part A (Hospital Insurance) covers skilled nursing facility (SNF) care on a short-term basis for Medicare beneficiaries that have a qualifying inpatient hospital stay. In 2021, about 14,700 SNFs furnished about 1.7 million Medicare-covered stays to 1.2 million fee-for-service (FFS)

beneficiaries, or 3.4 percent of Medicare's FFS beneficiaries. In that year, Medicare FFS spending on SNF services was $28.5 billion.[12]

SNFs are paid on the basis of a per diem prospective payment system (PPS). The SNF PPS payment rates are updated each Federal fiscal year using a SNF market basket index. Additionally, SNF PPS payments are adjusted for case mix to reflect the relative resource intensity that would typically be associated with a given patient's clinical condition, as well as for the geographic variation in wages. In 2019, CMS implemented the new Patient Driven Payment Model (PDPM), a SNF case mix model, that focuses on clinically relevant factors, rather than volume-based service for determining Medicare payment, by using ICD-10 diagnosis codes and other patient characteristics as the basis for patient classification. This improved classification system puts the unique care needs of patients first while also significantly reducing administrative burden associated with the SNF PPS.

In July 2022, CMS updated Medicare payment policies for SNFs under the SNF PPS for FY 2023. CMS estimates that the aggregate impact of the payment policies would result in an increase of 2.7 percent, or approximately $904 million, in Medicare Part A payments to SNFs in FY 2023 compared to FY 2022.[13] CMS issued the FY 2024 SNF PPS proposed rule last month, and estimates that the aggregate impact of the payment policies included would result in a net

[12] March 2023 Report to Congress: Medicare Payment, Skilled Nursing Facilities, Medicare Payment Advisory Committee https://www.medpac.gov/wp-content/uploads/2023/03/Ch7_Mar23_MedPAC_Report_To_Congress_SEC.pdf.
[13] Fact Sheet, Fiscal Year 2023 Skilled Nursing Facility Prospective Payment System Final Rule, CMS https://www.cms.gov/newsroom/fact-sheets/fiscal-year-fy-2023-skilled-nursing-facility-prospective-payment-system-final-rule-cms-1765-f.

increase of 3.7 percent, or approximately $1.2 billion, in Medicare Part A payments to SNFs in FY 2024.[14]

Medicaid Payments to Nursing Homes

Nursing facility services are the second-largest category of Medicaid spending after hospital services, and Medicaid is the primary payer for long-term care, including nursing facility care and home and community-based services (HCBS), in the United States. Nursing facility services are provided by Medicaid certified nursing homes, which primarily provide three types of services: skilled nursing, rehabilitation, and long-term care. A Nursing Facility (NF) participating in Medicaid must provide, or arrange for, nursing or related services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specific to each state, the general responsibilities of the NF are shaped by the definition of NF service in the state's Medicaid state plan, which may also specify certain types of limitations to each service. States may also devise levels of service or payment methodologies by acuity or specialization of the nursing facilities.

Under Medicaid's federal-state partnership, states have broad authority to determine Medicaid payment rates to NFs, which are generally paid on a per diem basis. According to MedPAC, combined state and federal fee-for-service Medicaid spending was $38.4 billion in 2021.[15]

[14] Fact Sheet, Fiscal Year 2024 Skilled Nursing Facility Prospective Payment System Proposed Rule, CMS https://www.cms.gov/newsroom/fact-sheets/fiscal-year-fy-2024-skilled-nursing-facility-prospective-payment-system-proposed-rule-cms-1779-p#:~:text=In%20the%20FY%202024%20SNF%20PPS%20proposed%20rule%2C%20CMS%20is,measure%20in%20the%20SNF%20QRP.

[15] March 2023 Report to Congress: Medicare Payment, Skilled Nursing Facilities, Medicare Payment Advisory Committee https://www.medpac.gov/wp-content/uploads/2023/03/Ch7_Mar23_MedPAC_Report_To_Congress_SEC.pdf.

As an alternative to long-term care provided in institutions such as nursing facilities, state Medicaid programs have the option to offer an array of long-term services and supports in beneficiaries' own homes and communities through various home and community-based services (HCBS) authorities under Medicaid. The Biden-Harris Administration, and CMS, remain committed addressing the longstanding institutional bias towards institutional settings in Medicaid and ensuring that individuals have access to quality home and community-based services and supports.

Making the Quality of Care More Transparent

Improvements to Nursing Home Care Compare

CMS created the Nursing Home Five-Star Quality Rating System to help consumers, their families, and caregivers compare nursing homes more easily and to help identify areas about which they may want to ask questions. The Nursing Home Care Compare website features a quality rating system that gives each nursing home a rating of between 1 and 5 stars. Nursing homes with 5 stars are considered to have quality that is far above average, and nursing homes with 1 star are considered to have quality that is far below average. There is one overall 5-star rating for each nursing home, and separate ratings for health inspections, staffing and quality measures. Consumers can find and compare Medicare- and Medicaid-certified nursing homes based on a location and can compare their staffing and the quality of care they provide.

In January 2023, CMS announced plans to take a new step to increase the transparency of nursing home information by publicly displaying survey citations that facilities are disputing.

When a facility disputes a survey deficiency, that deficiency was not posted to Care Compare until the dispute process was completed. This process usually took approximately 60 days or in some cases longer. While the number of actual deficiencies under dispute is relatively small, they can include severe instances of non-compliance such as immediate jeopardy level citations. This level of citation occurs when the health and safety of residents could be at risk for serious injury, serious harm, serious impairment or death. Displaying this information while it is under dispute can help consumers make more informed choices when it comes to evaluating a facility.[16]

Nursing Home Ownership Data

CMS has taken unprecedented steps regarding transparency in ownership of nursing homes, including by collecting and publicly reporting more robust corporate ownership and operating data. Making facility ownership information transparent supports efforts to identify common owners that have had histories of poor performance, to analyze data and trends on how market consolidation increases consumer costs without necessarily improving quality of care, and to evaluate the relationships between ownership and changes in health care costs and outcomes.[17]

In April 2022, as part of the President's efforts to increase competition and transparency, CMS publicly released, for the first time, data on mergers, acquisitions, consolidations, and changes of ownership from 2016-2022 for nursing homes enrolled in Medicare. This data, now available on data.cms.gov, is a powerful new tool for researchers, state and federal enforcement agencies, and

[16] "Biden-Harris Administration Takes Additional Steps to Strengthen Nursing Home Safety and Transparency" https://www.cms.gov/newsroom/press-releases/biden-harris-administration-takes-additional-steps-strengthen-nursing-home-safety-and-transparency.

[17] "For the First Time, HHS Is Making Ownership Data for All Medicare-Certified Hospice and Home Health Agencies Publicly Available" https://www.hhs.gov/about/news/2023/04/20/first-time-hhs-making-ownership-data-all-medicare-certified-hospice-home-health-agencies-publicly-available.html.

the public to better understand the impacts of consolidation on health care prices and quality of care. In September 2022, CMS released additional data publicly on the ownership of approximately 15,000 nursing homes certified as a Medicare Skilled Nursing Facility, regardless of any change in ownership, including providing more information about organizational owners of nursing homes.[18]

To further increase transparency and accountability, CMS issued a proposed rule in February 2023 that would require nursing homes to disclose additional ownership and management information, including information regarding individuals or entities that provide administrative services or clinical consulting services to the nursing homes. The proposed rule would also require additional information about entities that lease or sublease property to nursing homes and defines "private equity company" and "real estate investment trust ownership" for the purposes of provider enrollment and disclosure. CMS is also taking steps to require Medicare SNFs and other providers to disclose private equity company and real estate investment trust ownership interests via a revision to the Medicare enrollment application used by these providers.

In addition to fostering competition that drives high-quality care, transparent ownership data benefits the public by assisting patients, and their loved ones, in making more informed decisions about care. Analyzing this data will support CMS efforts to develop policy approaches that can

[18] "Biden-Harris Administration Continues Unprecedented Efforts to Increase Transparency of Nursing Home Ownership" https://www.cms.gov/newsroom/press-releases/biden-harris-administration-continues-unprecedented-efforts-increase-transparency-nursing-home#:~:text=In%20September%202022%2C%20CMS%20released,organizational%20owners%20of%20nursing%20homes.

improve competition in health care, a key priority for the Administration's strategy to reduce health care costs.

Nursing Home Proposals in the President's FY 2024 Budget

Survey and Certification Program Funding Increase and Program Improvements

The President's Fiscal Year (FY) 2024 budget includes multiple provisions to further strengthen nursing home oversight, transparency, and enforcement. CMS has seen an increase in the overall number of nursing home complaints since 2015, requiring additional survey resources during a time when enacted funding has generally been held constant. Specifically, compared to 2015, in recent years State Survey Agencies (SAs) conducted over 10,000 additional complaint surveys - a 19 percent increase - resulting, in part, in a 43 percent increase in the number of immediate jeopardy citations issued in that same time period.[19] A strong Survey and Certification program promotes patient safety and quality and may limit more severe enforcement action over time by detecting and correcting issues earlier. In light of this, the President's FY 2024 budget requests $566 million for Survey and Certification, an increase of $159 million or 39 percent above the FY 2023 enacted level. This investment will strengthen the health, quality, and safety oversight for approximately 67,000 participating Medicare or Medicaid provider and supplier facilities and is needed to support the CMS actions outlined in the 2022 White House fact sheet aimed at improving safety and quality of care in the nation's nursing homes.

The President's Budget also proposes a number of policy improvements to the Survey and Certification Program. CMS requires long-term care facilities to be recertified annually for

[19] Department of Health and Human Services, Fiscal Year 2024 Budget in Brief https://www.hhs.gov/sites/default/files/fy-2024-budget-in-brief.pdf.

participation in the Medicare program regardless of the overall quality of the facility. By contrast, CMS currently uses a risk-based approach for other facility types based on risk of poor care. The Budget proposes implementing a risk-based approach for long-term care facilities, which would allow CMS to survey high-performing facilities less frequently and redirect resources to strengthen oversight, including increasing facility inspections and quality improvement for low-performing facilities, where they are most needed. The President's Budget also proposes permitting the Secretary to charge long-term care facilities "resurvey fees" after a third visit is required to validate the correction of deficiencies that were identified during prior survey visits. Current law prohibits CMS from imposing fees on providers or suppliers for the purpose of conducting these surveys. In addition, the Budget proposes to increase the level of civil money penalties against long-term care facilities for failure to comply with federal participation requirements in Medicare and creates a penalty scale based on the severity of the deficiencies within a facility.

Hold Facility Owners Accountable for Noncompliant Closures and Substandard Care

When a long-term care facility closes, it is typically the owner of the facility that has control of its finances (including profits) and authority over the closure, and not the facility administrator. Yet under the current statute, it is the administrator that is at risk of being imposed a civil money penalty, and the owner has no accountability if they close the facility in a noncompliant manner. This proposal in the President's Budget would change the individual subject to a civil money penalty from "administrator" to "owner, operator, or owners or operators" of a facility and would add a provision that grants the Secretary authority to impose enforcement on the owners of a facility after the facility has closed. The FY2024 budget proposal would allow for enforcement

actions to be imposed against owners or operators of multiple facilities that provide persistent substandard and noncompliant care in their facilities. Further, CMS would be able to prohibit an individual or entity from obtaining a Medicare or Medicaid provider agreement for a nursing home based on the Medicare compliance history of their other owned or operated facilities. These changes will help solve a whack-a-mole problem and create accountability for owners with a track record of poor-performing homes.

Nursing Home Care Compare Website Data Validation

The FY 2024 Budget would require CMS to validate data submitted by nursing homes for the Nursing Home Care Compare website. Care Compare allows consumers to find and compare Medicare- and Medicaid-certified nursing homes based on a location and compare their staffing and the quality of care they give. Under this proposal, CMS would be able to take enforcement action against facilities that submit data that is found to be inaccurate by the new validation process, which could include a two percent reduction in claims payments, similar to the existing payment reduction for facilities that do not submit complete SNF quality reporting data.[20]

Conclusion

The Administration is committed to continuing to improve the safety and quality of care at the nation's nursing homes. The time is now for a bold approach and a strengthened commitment to deliver on our moral responsibility to care for our nation's elders and people with disabilities, including our Veterans. Our continued action on nursing homes will be carefully coordinated alongside CMS's efforts to ensure that people can access long-term care in an appropriate setting

[20] Department of Health and Human Services, Fiscal Year 2024 Budget in Brief https://www.hhs.gov/sites/default/files/fy-2024-budget-in-brief.pdf.

of their choice, including through home and community-based services. We look forward to working with Congress, industry experts, nursing home workers, resident advocates, and – most importantly – nursing home residents and their family members, to make these much-needed improvements.