

CENTER FOR MEDICARE ADVOCACY, INC.

ENFORCEMENT – IT'S IMPORTANT!

Consumer Voice
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ISSUES

How did we get where we are? (history of 1987 federal Nursing Home Reform Law and its implementation)

Current issues and concerns

What we can do to advocate for change at the federal and state levels

HISTORY

History of Institute of Medicine report (1986), how it influenced the enforcement provisions of the 1987 Nursing Home Reform Law, implementation of enforcement provisions of Reform Law by HCFA and CMS

HCFA's analysis of non-regulatory initiatives and enforcement (1998) and current findings

PRE-NURSING HOME REFORM LAW

Multiple state and federal reports saying

Limited number of sanctions available (essentially, only termination)

Cumbersome and time-consuming procedures

PROPOSED REGULATIONS (1982)

Proposed regulations, 47 Fed. Reg. 23,403 (May 27, 1982)

Less-than-annual surveys

Self-surveys by nursing facilities

Deemed status for Joint Commission on Accreditation of Healthcare Organizations (JCAHO), which scheduled surveys and kept survey results confidential

CONGRESSIONAL RESPONSE

Two legislative moratoria prohibited deregulation. Congress reached agreement with Health Care Financing Administration (HCFA), predecessor to CMS, as second moratorium was about to expire, to fund Institute of Medicine study. No deregulation permitted while study underway.

INSTITUTE OF MEDICINE (1986)

Four problems with enforcement

Federal and state attitudes towards enforcement

Federal rules and procedures

State variations in enforcement authority, policies, and procedures

Inadequate federal and state resources committed to enforcement



FEDERAL AND STATE ATTITUDES TOWARD ENFORCEMENT (IoM)

“Federal procedures for dealing with facilities found to be out of compliance are oriented toward helping facilities to improve rather than enforcing the certification standards.” (IoM, p. 147)

Result: Federal approach “allows states to continue certifying facilities that provide poor or marginal care.” (IoM, p. 147)

FEDERAL AND STATE ATTITUDES TOWARD ENFORCEMENT (IoM)

“The current survey policies and procedures encourage states to consult and coerce facilities into compliance, not to punish them.” (IoM, p. 148)

State gives facilities a chance to correct; formal sanctions may be imposed “only if the facility remains in violation beyond the deadline set for compliance.” (IoM, p. 148)

“[T]he facility is not punished for violations directly, but rather for failing to carry out an administrative order to correct violations by a certain date.” (IoM, p. 148)

“Resort to formal sanctions by a compliance-oriented agency therefore becomes the last step in a long series of follow-up visits and plans of correction designed to induce conformity on the part of substandard facilities.” (IoM, p. 148)

FEDERAL AND STATE ATTITUDES TOWARD ENFORCEMENT (IoM)

“[C]urrent federal policies requiring consultation undermine state agency efforts to eliminate substandard providers and deter marginal facilities from repeating violations.” (IoM, p. 149)

FEDERAL AND STATE ATTITUDES TOWARD ENFORCEMENT (IoM)

IoM recommends modifying federal and state enforcement procedures “to reorient the program toward enforcement rather than consultation and to encourage states to adopt a stronger enforcement posture” by “(1) separating the consultant and surveyor roles, (2) making survey follow-up procedures more specific, (3) making federal and state sanctions more comprehensive and applying them more rigorously, and (4) increasing both federal oversight and federal support of state enforcement activities.” (IoM, p.



FEDERAL RULES AND PROCEDURES: CONSULTATION (IoM)

Consultation: “[P]otential conflict between the consulting and regulatory roles of a survey agency.” (IoM, p. 150)

“Without a credible threat of sanctions, many marginal or poor facilities never improve.” (IoM, p. 150)

FEDERAL RULES AND PROCEDURES: SURVEY FOLLOW-UP AND PROCEDURES (IoM)

Survey Follow-up Procedures “do not specify how plans of correction should be evaluated, how correction actions should be measured, or when more stringent enforcement actions should be initiated.” (p. 150)

“Current federal sanctions are inadequate.” Termination is the only federal sanction and rarely used “because of the undesirability of closing facilities and relocating residents.” (p. 155)

STATES DESCRIBED EFFECTIVE SANCTIONS (IoM)

States say sanctions are effective when they

“affect the income of the provider”

“can be implemented quickly”

“give the provider unwanted publicity”

“can be used to remove the operator.” (IoM, p. 164)

STATES DESCRIBED OBSTACLES TO SUCCESSFUL USE OF SANCTIONS (IoM)

States describe obstacles to successful use of sanctions:

“administrative and legal time delays in implementation”

“administrative problems”

“fear of harm to residents (transfer trauma, service cutbacks to pay fines, and so on)”

“insufficient impact on the provider’s income.” (IoM, p. 164)



IoM RECOMMENDATIONS

Strengthen enforcement by

specifying that survey agency personnel are not consultants to facilities

specifying circumstances requiring formal enforcement

authorizing specific sanctions

making facilities' appeals process less permissive



IoM RECOMMENDATIONS (cont'd)

Strengthen enforcement by

requiring states to commit adequate resources, including legal and other staff

providing more training in investigatory techniques, witness preparation, and the legal system

NURSING HOME REFORM LAW (1987)

IoM recommendations were blueprint/ legislative history of 1987 Nursing Home Reform Law (part of Omnibus Budget Reconciliation Act of 1987)

Reform Law defined Secretary's responsibility broadly: to assure federal standards of care and their enforcement are "adequate to protect the health, safety, welfare, and rights of residents and to promote the effective and efficient use of public moneys." 42 U.S.C. §§1395i-3(f)(1), 1396r(f)(1), Medicare and Medicaid, respectively.



NURSING HOME REFORM LAW (cont'd)

Required all states to enact a specified list of intermediate sanctions (and, other than civil money penalties, permit their use during the pendency of administrative appeals).

Required specified mandatory remedies for repeated or uncorrected deficiencies.

Required state enforcement systems to “minimize the time between the identification of violations and final imposition of the remedies.”

42 U.S.C. §§ 1395i-3(h), 1396r(h)



POST-LAW, PRE-REGULATION

American Health Care Association video urged members commenting on proposed regulations to ask HCFA to

Require use of scope and severity scales to determine existence of deficiencies

Require states to offer facilities alternative dispute resolution in addition to formal appeals process



POST-LAW, PRE-REGULATION (cont'd)

HCFA Work Group (1989)

Discussed survey issues, not enforcement

Draft revised and strengthened by Office of General Counsel

Proposed rules, 57 Fed. Reg. 39,278 (Aug. 28, 1992)

FINAL REGULATIONS

59 Fed. Reg. 56,116 (Nov. 10, 1994), effective July 1, 1995, with themes of

State flexibility

Use of State Operations Manual, rather than regulations, to explain statutory requirements in more detail

Conscious balancing and mediating differences between consumers and providers



FINAL REGULATIONS (cont'd)

HCFA added AHCA's two main points from pre-regulation advocacy

HCFA created new regulatory term, substantial compliance, to tolerate some deviation from full compliance with Requirements of Participation

HCFA required states to have an informal dispute resolution process

STATE OPERATIONS MANUAL

Strong introduction

But, SOM

created new term, “date certain,” that allows facilities an opportunity to correct before remedies are imposed;
discouraged states from using enforcement;
minimized federal oversight role (Regional Office to accept state recommendation “except in the most extraordinary circumstances”).

HCFA OVERSIGHT OF ENFORCEMENT

Convened two outside monitoring groups

“Situation Room” in Central Office, Baltimore, to review and analyze states’ survey reports

Message: HCFA is looking at deficiencies that states cite.
If no deficiencies are cited, there is no federal review.

INFORMAL CHANGES AFTER 1995

- Later revisions to SOM continued to revise enforcement. HCFA
 - Imposed moratorium on collection of CMPs
 - Changed definition of “widespread” scope
 - Created new terms for facilities not in substantial compliance
 - Issued interim revisit policy (avoiding revisits if deficiencies at levels D-E-F)
 - Encouraged states to limit CMPs to poor performers or serious deficiencies
 - Modified informal dispute resolution process

JULY 1998

White House announced Nursing Home Initiative (24 points).

HCFA released report to Congress on accreditation, regulatory incentives, and non-regulatory quality initiatives.

Senate Special Committee on Aging began series of hearings on nursing home issues (enforcement, bankruptcy, staffing, etc.).



HCFA CHANGES TO SURVEY

Increased sample size

Developed quality indicators to help surveyors identify potential problems in facilities (indicators are not a measure of facility quality)

Developed new survey task for abuse prevention review

Created new federal monitoring process (Federal Oversight/Support Survey)



HCFA CHANGES TO ENFORCEMENT

Clarified the revisit policy to require revisits for deficiencies at level G and above

Revised mandatory criteria for poor-performing facility with mandatory remedies

Identified Special Focus Facilities

Required 10% of surveys to begin on off- hours

HCFA REPORT ON ACCREDITATION, NON-REGULATORY INITIATIVES, AND SURVEY AND CERTIFICATION

Non-regulatory initiatives

Most initiatives have no evaluation component

Two initiatives with evaluation components

Incontinence management: gains ended when research ended

Ohio Pressure Ulcer Initiative: intervention was **not** effective in reducing pressure ulcers), Vol. II, pages 375-382.

HCFA concluded: giving feedback on performance and providing educational “best practices” information do not change care practices, Vol. I (Executive Summary), page vi (“We have found little to no evidence to support a belief in the effectiveness of these initiatives *as they are normally implemented in nursing homes.*”)



HCFA REPORT ON ACCREDITATION, NON-REGULATORY INITIATIVES, AND SURVEY AND CERTIFICATION (cont'd)

HCFA found positive changes in resident health status resulting from regulation

1994-1997: Hospitalization of residents declined from 21% to 15%; use of psychopharmacologic medications declined from 33.7% to 16.1%

“[T]he new enforcement regulation was effective in improving resident status outcomes.” Vol. 1, Executive Summary, page ix.

HCFA, *Report to Congress; Study of Private Accreditation (Deeming) of Nursing Homes, Regulatory Incentives and Non-Regulatory Initiatives, and Effectiveness of the Survey and System* (1998)



NURSING HOME INITIATIVE (2001)

Nursing Home Initiative (Nov. 2001)

Public reporting of performance measures (market-based approach, rather than regulatory approach)

Technical assistance through Quality Improvement Organizations

Revisions to State Operations Manual

Quality-based purchasing demonstration

CMS evaluation found demonstration did not lower Medicare spending or improve quality, L&M Policy Research, Evaluation of the Nursing Home Value-Based Purchasing Demonstration, page 50, Contract No. HHSM-500-2006-0009i/TO

http://innovation.cms.gov/Files/reports/NursingHomeVBP_EvalReport.pdf



SENATE FINANCE COMMITTEE HEARING (2003)

Senate Finance Committee hearing: “Nursing Home Quality Revisited: The Good, the Bad, and the Ugly,” S.Hrg. 108-325 (July 2003)

William Scanlon, Director, Health Financing and Public Health Issues, GAO, testified about what he learned in 6 years of leading GAO’s work on nursing home issues

“pressing need to ensure a minimum quality of care in every nursing home”

Surveyors should be perceived as “consumer representatives,” not consultants

We haven’t implemented survey and enforcement “as envisioned in OBRA ‘87”

“The execution of survey and enforcement action that should follow them have been so lacking, we do not know how effective the process can be.”



ENFORCEMENT

Study of antipsychotic drug deficiencies cited by 7 states in 2011 and 2012 found 95% were cited at “no harm” levels (meaning enforcement unlikely)

Edelman and Lerner, “CMA Report: Examining Inappropriate Use of Antipsychotic Drugs in Nursing Facilities” (Weekly Alert, Dec. 12, 2013), <http://www.medicareadvocacy.org/cma-report-examining-inappropriate-use-of-antipsychotic-drugs-in-nursing-facilities/>. Full report at <http://www.medicareadvocacy.org/examining-inappropriate-use-of-antipsychotic-drugs-part-one-how-seven-states-cite-antipsychotic-drug-deficiencies/>



NURSING HOME INDUSTRY

Industry proposes voluntary programs to improve quality

Quality First Initiative (July 2002)

Advancing Excellence (Oct. 2006) (Voluntary 5-year plan to improve quality of care; now extended indefinitely)

American Health Care Association, *Quality Initiative* (2012)

Remember: 1998 HCFA report: voluntary programs do not work.

See also CMA, “The Myth of Improved Quality in Nursing Home Care: Setting the Record Straight Again” (Weekly Alert, Apr. 17, 2014),

<http://www.medicareadvocacy.org/the-myth-of-improved-quality-in-nursing-home-care-setting-the-record-straight-again/>



NURSING HOME INDUSTRY (cont'd)

Opposed enforcement in 1987, still does

AHCA, proposes survey reform (undated)

CMA, “Back to the Future: Nursing Home Industry Makes Secret Survey and Enforcement Proposals to Congress” (Weekly Alert, Apr. 16, 2009), http://www.medicareadvocacy.org/InfoByTopic/SkilledNursingFacility/SNF_09_04.16.SecretSurvey.htm.

LeadingAge, *Broken and Beyond Repair* (2008)

LeadingAge calls for new study of oversight

CMA, “Federal Nursing Home Enforcement System Is Not Punitive: Setting the Record Straight Again” (Weekly Alert, May 8, 2014), <http://www.medicareadvocacy.org/federal-nursing-home-enforcement-system-is-not-punitive-setting-the-record-straight-again/>



TRANSPARENCY AND ACCOUNTABILITY (2012)

Nursing home sections of Affordable Care Act

Nursing Home Compare requirements, including

Payroll-based staffing data

Ownership information

Nursing home expenditure data

Links to state websites (and 2567s)

Reporting of crimes against residents to law enforcement

National Independent Monitor Demonstration Project (chains)

Dementia and abuse training for nursing home staff

Quality Assurance and Performance Improvement



WHERE WE ARE TODAY

Implementing IoM recommendations (1986), Congress strengthened survey and enforcement requirements in Nursing Home Reform Law (1987).

HCFA (1998) found little value in non-regulatory initiatives and positive results of regulation and enforcement.

HCFA and CMS (1987-present): implementation has generally been weak; continued reliance on technical assistance (now “partnerships”) and termination, not effective use of intermediate sanctions.

CYNTHIA



WHERE ARE WE NOW?

Instead of a regulatory approach to quality oversight, as required by the Nursing Home Reform Law, CMS focuses on a market-based approach.

CMS'S MARKET-BASED APPROACH

Nursing Home Compare reflects market-based approach to improving quality of care (i.e., give consumer information and let them decide where to get care)

But “Market “ does not work in this area

Consumers and SNFs do not have equal information or equal bargaining power

Consumers have little or no real choice when selecting a SNF or in moving to another facility if dissatisfied



COLLABORATION

CMS sees its role as training/working with/collaborating with industry

E.g., CMS's antipsychotic drug initiative became "National Partnership to Improve Dementia Care"

CMS posts all information on antipsychotic drugs on *Advancing Excellence* website, not on a CMS website

QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT (QAPI)

QAPI is required by §6102(c) of Affordable Care Act (health care reform law) and a main provision CMS is implementing

But QAPI is a management tool for facilities to identify and correct quality problems

As described by CMS technical assistance materials, QAPI is time- and staff-intensive

QAPI

QAPI is redundant but more limited than current rules for plans of correction

Plan of correction process already requires facilities to identify and correct care problems, as identified in deficiencies, to assure that the problem is fixed for the resident(s) cited and for other residents and to take sufficient action to ensure that deficient practices do not recur for any residents.

QAPI

CMS seems ready to reduce survey and certification activities in facilities that have QAPI

e.g., proposed home health regulations, 79 Federal Register 61,163, at 61,166-61,167 (Oct. 9, 2014) (proposed rules reflect “fundamental change in our regulatory approach”)