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Centers for Medicare & Medicaid Services
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Delivery by courier

Re: CMS-2435-P
Civil Money Penalties for Nursing Homes

Dear CMS Colleagues:

The Center for Medicare Advocacy, California Advocates for Nursing Home Reform, and the National Senior Citizens Law Center thank you for the proposed regulations, which put the rights and interests of nursing home residents firmly at the center of the public oversight system and will help assure that residents receive the high quality of care and quality of life that they are entitled to receive under federal law. The proposed regulations strengthen the civil money penalty (CMP) system that has been in place for more than 15 years. They recognize that Congress intended in the Affordable Care Act (ACA) to “improve the efficiency and effectiveness of the nursing home enforcement process” by reducing delay in facilities’ appeals and by making penalties more effective in motivating facilities to maintain continuous compliance.

In particular, we support your proposals to

- Authorize the accrual of CMPs during an administrative appeal;
- Narrowly construe the circumstances when a 50% reduction in CMPs may be made;
- Require notification of residents and their representatives and the state ombudsman program about their opportunity to provide a written statement in an independent informal dispute resolution (IIDR) proceeding;
- Require facilities to pay the costs of IIDR, if they choose IIDR instead of informal dispute resolution (IDR);
- Authorize the use of 50% of federal CMPs for programs benefiting residents.

We discuss these points in detail below and make additional recommendations to improve and strengthen the federal enforcement system.

1. Escrow accounts and the accrual of CMPs during a facility's formal administrative appeal

CMS correctly recognizes that Congress, in the portion of the ACA entitled "Targeting Enforcement," intended, broadly, to improve the efficiency and effectiveness of the nursing home enforcement process and, more specifically, to reduce the delays in the collection of CMPs. At present, CMPs are the only remedy under the 1987 Nursing Home Reform Law that is not implemented until completion of the formal administrative appeal. As a consequence, most facility appeals are about CMPs.¹

The Government Accountability Office (GAO) recommended in 2007 that CMS seek legislative authority to require placement of CMPs in escrow accounts, pending completion of the administrative appeal. GAO, *Nursing Homes: Efforts to Strengthen Federal Enforcement Have Not Deterred Some Homes from Repeatedly Harming Residents*, page 60, GAO-07-241 (March 2007), <http://www.gao.gov/new.items/d07241.pdf>. CMS agreed with the recommendation.

Congress responded to the GAO recommendation in §§6111(a) and (b) of the ACA by adding a new subsection (IV)(bb) to 42 U.S.C. §§1395i-3(h)(2)(B)(ii), 1396r(h)(3)(C)(ii), to authorize the placement of CMPs in an escrow account, following IIDR, if a facility requests IIDR.

CMS correctly interprets the law to authorize the accrual of the CMP during IIDR, but not to require

¹ In a 2008 report, *Nursing Home Decisions of the Department of Health and Human Services's Departmental Appeals Board, 2007*, the Center for Medicare Advocacy reviewed all 85 decisions in federal administrative appeals by nursing homes that were issued in 2007. The Center found that the 41 decisions that addressed the merits of facility appeals involved CMPs, either alone or in combination with other remedies. In only five cases with clearly identified remedies did CMS impose remedies other than CMPs. http://www.medicareadvocacy.org/InfoByTopic/SkilledNursingFacility/SNF_08_05.13.DABNursingHomeDecisions.pdf

the placement of CMPs into the escrow account until IIDR is completed. CMS's analysis is the only reasonable interpretation of the statutory language, in context. 75 Fed. Reg., 39643-644.

As CMS first points out, an interpretation that suspends the accrual of a CMP during the IIDR process would result in *no CMP being available* to be placed in the escrow account. *Id.* 39643. Second, under longstanding federal rules, CMPs may accrue from the first date of noncompliance and they continue to accrue until a facility either achieves substantial compliance or is terminated. The ACA did not change this basic principle of the federal enforcement process; it simply added a new provision to allow for placement of CMPs in escrow accounts pending a formal administrative appeal. And finally, as CMS articulates, "suspending the accrual of a civil money penalty while the underlying noncompliance was being informally challenged would undermine such motivational effects." *Id.* 39644. Congress explicitly intended to strengthen the enforcement system. CMS's regulatory language and explanation further that Congressional goal. No other interpretation would fulfill Congressional intent. We fully support the proposed language at §488.41(b)(2) to this effect.

For similar reasons, we support CMS's proposal to retain CMPs in the escrow account until the Departmental Appeals Board (DAB) has ruled in any case where the Administrative Law Judge (ALJ) has reversed a CMP determination, in whole or in part (by reducing or rejecting entirely the CMP proposed by CMS).

Recommendation

a. We recommend that CMS explicitly require that CMPs be deposited in escrow accounts whenever facilities request either IIDR or IDR.

As written, proposed §488.431(b) may appear to limit the requirement for facilities to deposit CMPs in escrow accounts to situations where IIDR is sought (unless the facility allows the 90-day period to lapse without requesting either IDR or IIDR). We recommend that CMS clarify the rules, and exercise its discretion, to require that facilities place CMPs in escrow accounts, whether a facility chooses IIDR or IDR. There is no rationale for treating CMPs differently, for purposes of escrow accounts, depending on the type of informal dispute resolution process a facility chooses.

First, the statutory language at §6111 of the ACA, adding a new (IV) to §1395i-3(h)(5) and to §1396r(h)(3)(C), although somewhat unclear and ambiguous, appears to use IIDR and IDR almost interchangeably. The language refers in subsection (aa) to IIDR, in subsection (bb) to IDR, and in section, to IDR, as described in (aa).

Second, when the GAO recommended use of escrow accounts in 2007, IIDR did not exist in the statute and the only option for facilities for an informal challenge to a CMP was IDR. GAO, *Efforts to Strengthen Federal Enforcement Have Not Deterred Some Homes from Repeatedly Harming Residents*, page 34, GAO-07-241 (March 2007), <http://www.gao.gov/new.items/d07241.pdf>. The GAO plainly intended that escrow accounts be used for any CMPs that were imposed against facilities and CMS agreed to seek legislative authority to implement the recommendation. *Id.* 84, Appendix VI (Comments of CMS), Comment C.1. Neither the GAO nor CMS intended to limit the escrow requirement to IIDR, since that option did not exist

under federal law.

2. 50% reduction in CMP for self-reporting and full correction within 10 days

The ACA authorizes a reduction of a CMP of up to 50% when a facility self-reports and promptly corrects a deficiency that gave rise to the CMP. §§1395i-3(h)(2)(B)(ii)(II), 1396r(h)(3)(C)(II).

CMS correctly interprets the statute’s somewhat confusing language to mean that, in order to receive a reduction in the amount of a CMP, a facility must report the deficiency to CMS **before** the deficiency is reported to CMS or a state through a complaint investigation and **before** CMS identifies the deficiency in a survey. Proposed §488.438(c)(2)(i), (ii). No other interpretation would make sense of the term “self-report.”

As required by the ACA, CMS also proposes that deficiencies be ineligible for a 50% reduction – even if self-reported and corrected within 10 days – if the deficiency involved immediate jeopardy, a pattern of harm, widespread harm, or the death of a resident. We fully support CMS’s statement, “Noncompliance at these scope and severity levels indicates a significant breakdown in facility performance and systems to the extent that, even if self-reported, warrants an equally significant consequence without the benefit of a considerable reduction.” 75 Fed. Reg., at 39645.

We also fully support, as required by the ACA, CMS’s proposed refusal to allow a 50% reduction in CMP for repeated noncompliance. *Id.* CMPs for deficiencies in the same regulatory grouping, as defined at 42 C.F.R. §488.438(d)(3) (and including such broad regulatory categories as quality of care) should not be subject to a 50% reduction. Facilities must be able to maintain compliance in order to benefit from such a large reduction in a CMP.

Using the 50% figure instead of a sliding scale, as CMS proposes, leads to ease of administration and also serves, as CMS recognizes, as a strong motivator for facilities. We support CMS’s decision to authorize a 50% reduction in CMPs for self-reported deficiencies that are fully corrected within 10 days.

We support proposed §488.438(c)(2), as drafted.

Recommendation

a. We recommend that CMS define what “correction” means, for purposes of the 50% reduction in the CMP. We take guidance from CMS’s long-standing requirements for facility plans of correction. The State Operations Manual, chapter 7, §7000, which implements 42 C.F.R. Part 488, says:

In order for a plan of correction to be acceptable, it must:

1. Contain elements detailing how the facility will correct the deficiency as it relates to the individual;
2. Indicate how the facility will act to protect residents in similar situations;
3. Include the measures the facility will take or the systems it will alter to ensure that the problem does not recur;

4. Indicate how it plans to monitor its performance to make sure that solutions are sustained; and

5. Provide dates when corrective action will be completed.

If a submitted plan of correction fails to adequately address all of these points, or if the correction dates are unacceptable to the State, the plan of correction would not be acceptable.

See also §7304D.

Firing an abusive aide is not sufficient correction, for example. In order to demonstrate “correction,” the facility would need to demonstrate that it took steps to identify what caused the problem with the aide – recruiting, or training, or supervising, or supporting with sufficient supplies and adequate staffing levels, or some combination of the factors – and that it corrected all of them. For similar reasons, transferring a resident to a hospital is also not sufficient correction.

Based on longstanding guidance in the SOM, we believe that correction must mean correction not only for the individual resident(s) who was/were affected by the facility’s noncompliance, but also correction for other residents who are subject to the same deficiency.

3. Independent informal dispute resolution

Residents’ advocates opposed the proposal for IIDR in the ACA, seeing the proposal as an effort by the nursing home industry to create another obstacle to effective enforcement of federal standards of care. The industry effort was particularly disturbing in light of the fact that residents, their families, and advocates have no comparable opportunity for IDR to challenge why survey agencies did *not* cite deficiencies. Nevertheless, IIDR is now part of federal law. Although we believe CMS has appropriately interpreted the statutory language, we encourage CMS to closely monitor the implementation of IIDR.

We support CMS’s proposal to charge facilities the actual costs of IIDR, if they choose to use that mechanism rather than IDR. Facilities have the choice to use IDR at no cost. If they want a different process, they should be required to pay for it.

In response to CMS’s questions on page 39647 about user fees, we do not support refunding user fees to facilities under any circumstances. For the reasons set out below, we do not support refunding user fees when there is a change in the scope, severity, or quantity of deficiencies or when IIDR completely eliminates the deficiency that gave rise to the CMP.

First, the Secretary retains authority for survey findings and remedies and can overrule a state’s IIDR recommendation. Neither IIDR nor IDR is the final word about whether a deficiency exists and a remedy is imposed. *See, e.g., Britthaven of Chapel Hill v. CMS*, Docket No. C-08-327, Decision No. CR1942 (April 24, 2009).

<http://www.hhs.gov/dab/decisions/civildecisions/cr1942.pdf>. Second, even if a particular deficiency is changed or deleted in IIDR, CMS may impose the same CMP based on the remaining deficiency(ies). Since remedies are generally based on the totality of deficiencies (including both the number of deficiencies and their scope and severity), an IIDR-recommended change to a deficiency

may have little significance in the context of actual enforcement actions. Third, allowing for refunds of CMPs, based on whether a deficiency was changed in some way or deleted, would create enormous administrative complexities. The process would need to determine the value of a deleted example in a deficiency, compared to the value of a reduction in scope or severity of a deficiency, compared to the value of complete deletion of a deficiency. Such a process would also necessarily need to consider whether CMS agreed with the IIDR recommendation or cited the deficiency and imposed a CMP for the deficiency. Fourth, a facility has a dispute resolution option that costs the facility nothing – IDR. If the facility chooses IIDR, it presumably finds “added value” in the IIDR process, as compared with IDR. The facility should be bound by the financial decision it has made in choosing IIDR.

We also support CMS’s recommendation to allow residents and their families and the state long-term care ombudsman an opportunity to submit a written statement in the IIDR proceeding. §488.431(a)(3). Since residents are most directly affected by facilities’ noncompliance and the Nursing Home Reform Law was enacted to provide them with high quality of care, their voice must be heard when facilities informally, and formally, challenge deficiencies.

Recommendations

a. We recommend that CMS explicitly provide that IIDR be identical to IDR but for the entity that performs the review function. For example,

- Facilities have one opportunity to request either IDR or IIDR.
- IIDR, like IDR, must be limited to factual disputes about the existence of a deficiency or deficiencies.
- Facilities may not challenge the compliance of surveyors with the federal survey protocol (including scope and severity of deficiencies, except substandard quality of care or immediate jeopardy; remedies; alleged inconsistency of the survey team in citing deficiencies; alleged inadequacy of the IIDR process).
- Facilities may not use IIDR to delay the formal imposition of remedies.
- The Secretary retains authority for survey findings and remedies and can overrule a state’s IIDR recommendation. *See, e.g., Britthaven of Chapel Hill v. CMS*, Docket No. C-08-327, Decision No. CR1942 (April 24, 2009), <http://www.hhs.gov/dab/decisions/civildecisions/cr1942.pdf> (An IDR panel deleted one of two immediate jeopardy deficiencies that were cited and lowered the scope and severity of the other jeopardy deficiency to level G. CMS notified the facility in two letters that it *rejected* the IDR decision and that both deficiencies would be cited as jeopardy. (CMS also disagreed with the state’s recommendation to impose two per instance CMPs, each \$500. Instead, CMS imposed per day CMPs – \$3550, September 30-November 28, 2007; \$100, November 29, 2007-January 1, 2008 – totaling \$213,000.) ALJ Carolyn Cozad Hughes sustained both deficiencies and the per day CMPs imposed by CMS). Accordingly, we

support language at §488.431(a), “CMS retains ultimate authority for the survey findings and imposition of civil money penalties,”

See State Operations Manual, Chapter 7, §7212.

b. We recommend that CMS amend the regulations for IDR to allow residents and ombudsman programs an opportunity to participate in IDR proceedings, as the regulations propose for IIDR (§488.431(a)(3)). IDR and IIDR should have consistent processes, but for the entity that performs the review function.

c. We recommend that CMS explicitly include a prohibition on conflict-of-interest for an “independent entity with healthcare experience” that is selected by the state, and approved by CMS, to conduct IIDR. Proposed §488.431(a)(5)(ii). A nursing home trade association could be viewed as an “independent entity with healthcare experience,” but, for obvious conflict-of-interest reasons, it would not be an appropriate entity to conduct IIDR.

d. We recommend that a facility’s election of either IIDR or IDR should be final. A facility should not be permitted to switch from IIDR to IDR, once it makes an election of IIDR. This recommendation is based on the experience of the State of Minnesota, which, by state law, has authorized IIDR in addition to the federally-mandated IDR.

IIDR in Minnesota takes considerably more supervisory and surveyor time than IDR (232.25 hours compared to 106 hours, in 2007). Facilities choosing IIDR are required to reimburse the Minnesota Department of Health only for “costs that are attributable to disputed tags on which MDH prevails.” Minnesota Department of Health, *Annual Quality Improvement Report on the Nursing Home Survey Process; Report to the Minnesota Legislature* (Federal Fiscal Year 2007) (Released April 2008), page 17, <http://www.health.state.mn.us/divs/fpc/2007QINHreport.pdf>. If facilities withdraw their appeals, the state does not recoup costs. *Id.* 18. In fiscal year 2007, a “significant number” of IIDRs were withdrawn after MDH had completed its work but before IIDR occurred. MDH was unable to recoup staff time and expenses. *Id.*

Based on this state experience, we recommend that nursing facilities not be able to avoid the cost of IIDR by choosing, in the middle of the proceeding, either to drop IIDR entirely or to shift to IDR.

e. We recommend that CMS elaborate on what “at the facility’s expense” means. Proposed §488.431(a)(4). CMS must ensure that facilities not be permitted to seek or collect reimbursement from either Medicare or Medicaid for the charges for IIDR, including legal costs; the charges and legal costs should not be allowable costs. Facilities should fully bear the costs of IIDR.

f. We recommend that CMS establish a process to monitor, and, if appropriate, withdraw approval from, entities that conduct IIDR to ensure that they are serving residents’ best interests and not downgrading or deleting legitimate deficiencies and CMPs. Although CMS retains authority to approve the entities that may conduct IIDR, pursuant to proposed §488.431(a)(5), it should also oversee how these entities operate once approved. CMS should conduct periodic evaluations of entities conducting IIDR. Based on the findings, CMS should refine which organizations are eligible

to conduct IIDR and withdraw approval from entities that are not performing adequately.

4. Use of 50% of federal portion of CMPs for programs and projects benefiting residents

For the first time ever, CMS proposes that 50% of the federal portion of CMPs not be returned to the United State Treasury, but, instead, be used “entirely for activities that protect or improve the quality of care for residents.” Proposed §488.433. While fully supporting this recommendation, we want to ensure that the programs and projects are not already required and covered by public reimbursement and that they actually benefit residents.

The ACA identifies appropriate uses of CMP funds, including protecting residents during the voluntary or involuntary closure or decertification of their facility, supporting resident and family councils, and “other consumer involvement in assuring quality care in facilities.” 42 U.S.C. §§1395i-3(h)(2)(B)(IV)(ff), 1396r(h)(5)(IV)(ff). We support §488.433(c), which implements this statutory language.

Recommendations

a. We recommend that CMS insert the word “independent” before “resident” in §488.433(c). Resident and family councils need to be fully independent in order to represent resident and family interests effectively.

b. We recommend that the final regulations be amended to include state and local ombudsman programs. Proposed §488.433(c) could be amended to read:

(c) Projects that support independent resident and family councils and other consumer involvement in assuring quality care in facilities, including state and local long-term care ombudsman programs.

In “Use of Civil Money Penalty (CMP) Funds by States and Reporting of CMP Funds Returned to the State,” S&C-09-44 (June 19, 2009), CMS recognized that the ombudsman program is an appropriate recipient of CMP funds.

c. We recommend that CMS’s guidance document allow resident-focused uses of CMP funds, identified in §488.433(c)(1)-(3), to be made without per-request approval.

In addition to resident-focused programs, the ACA describes other appropriate uses of CMP funds to include “facility improvement initiatives,” such as “joint training of facility staff and surveyors, technical assistance for facilities implementing quality assurance programs.” *Id.* We are concerned that “facility improvement initiatives” may support programs and projects that facilities are already required to undertake under federal law. We are also concerned that the amount of money received under an “improvement initiative” may exceed the amount of CMPs imposed against the facility. We urge CMS to provide substantial additional guidance as to when CMPs may be used for “facility improvement initiatives” and to require advance approval on a case-by-case basis for any of these initiatives. As discussed below, we strongly recommend that CMS convene a meeting of interested

groups to help establish appropriate guidance.

d. We recommend that CMP funds not be used to fund programs and services that facilities are required to provide.

The ACA authorizes CMPs to be used for “quality assurance programs.” §6111, amending 42 U.S.C. §§1395i-3(h)(2)(B)(ii)(IV)(ff), 1396r(h)(3)(C)(IV)(ff). The proposed regulation says CMP funds may be used for a “quality assurance and performance improvement program.” Proposed §488.433(d). However, the ACA **requires** facilities to establish quality assurance and performance improvement programs (QAPIs). §6102, amending 42 U.S.C. §1301(c). Since facilities are mandated to implement QAPIs, CMP funds should not be used to support QAPIs. *See* “Use of Civil Money Penalty (CMP) Funds by States and Reporting of CMP Funds Returned to the State,” S&C-09-44 (June 19, 2009) (confirming that CMP funds should not be used for items or services “that the facility is responsible for and responsible for paying for”). CMP money should be available only for non-mandated quality assurance programs that benefit residents and improve their quality of life and quality of care.

We are also concerned about the use of CMP funds to support “culture change” projects. The Pioneer Network defines culture change as follows:

“Culture change” is the common name given to the national movement for the transformation of older adult services, based on person-directed values and practices where the voices of elders and those working with them are considered and respected. Core person-directed values are choice, dignity, respect, self-determination and purposeful living.

Culture change transformation supports the creation of both long and short-term living environments as well as community-based settings where both older adults and their caregivers are able to express choice and practice self-determination in meaningful ways at every level of daily life.

Culture change transformation may require changes in organization practices, physical environments, relationships at all levels and workforce models – leading to better outcomes for consumers and direct care workers without inflicting detrimental costs on providers.

Pioneer Network, “What Is Culture Change?” <http://www.pioneernetwork.net/CultureChange/>

This definition includes facility practices that federal law has required since the 1987 Nursing Home Reform Law was implemented in 1990. “Choice, dignity, respect, self-determination” are core principles of the Reform Law. Allowing residents to get up and go to sleep at times of their choice, for example, is not an innovation of culture change; it is a requirement of federal law. Facilities should not be eligible for CMP bonuses when they implement such programs. *See* Leslie A. Grant, *Culture Change in a For-Profit Nursing Home Chain: An Evaluation*, pages 18-19, 21, 22 (Feb. 2008),

http://www.commonwealthfund.org/usr_doc/Grant_culturechangefor-profitnursinghome_1099.pdf?section=4039 (study of culture change in facilities owned by Beverly

Enterprises found that seven “resident-centered care” (RCC) facilities implementing culture change, compared with 10 non-RCC facilities, gave residents more choices in food and dining and choice about daily activities, such as getting up and going to bed).

The American Health Care Association’s (AHCA’s) *Provider* magazine recently described 26 states’ activities in “culture change.” Seven of the 26 states use CMP money to fund culture change work, including training in the proprietary Eden Alternative or Greenhouse movement. “Culture Changes Close To Home,” *Provider* (May 2010),

<http://www.ahcancal.org/News/publication/Provider/ENOCultureChange.pdf>. As described by AHCA, North Carolina has used \$1,200,000 in CMP money, through the North Carolina Coalition for Long-Term Care Enhancement, “to help [69] skilled nursing facilities transform their cultures of care.” Massachusetts will use CMP money to “provide mentor services and up to \$10,000 grants to as many as 10 nursing facilities to implement consistent staffing and build an infrastructure in which continuous quality improvement can occur.” Although a fuller description of these projects would presumably provide more substantive detail, we remain concerned that CMP funds not be used for vague projects that are described “culture change.”

CMPs are now being used to support facility projects or training programs, under the rubric of culture change, that conflict with federal law. For example, AHCA describes Oregon’s use of an unidentified amount of CMP money to

support culture change using a partnership model of pairing surveyors with providers. These surveyors do not lead the teams, but function as a team member and resource to the teams about the regulations and help them problem-solve when change ideas or questions arise that the team has concerns about relative to regulation.

CMP funds in Oregon are used “to contract with a consultant to coach/coordinate the activities of the teams.” We strongly oppose surveyors “partnering” with facilities for any purpose; consultation with facilities is not an appropriate function for surveyors.

e. We recommend that CMP funds not be provided to facilities with serious deficiencies. We are particularly concerned that if facilities are eligible for CMP-funded projects, the amounts received will exceed the CMPs imposed on them. State programs providing incentive payments to nursing facilities have given extra payments to facilities providing poor care, dwarfing the CMPs that were imposed against the facilities.

In Iowa, a program paying Medicaid cash bonuses to facilities for factors such as “cost efficiency, occupancy rates and the availability of care for elderly people with dementia” gave bonuses averaging \$19,700 (and totaling \$8.3 million) to 81% of the state’s nursing facilities. Clark Kauffman, “State pays bonuses to worst of homes,” *The Des Moines Register* (March 2, 2008). (Although annual inspections were another factor considered in awarding bonuses, 90% of Iowa’s facilities received no points in the bonus program for their inspection results.) Most troublesome, *The Des Moines Register* reported, “this year’s bonuses more than offset last year’s fines that were levied by state regulators” against some facilities. *The Des Moines Register* provided examples:

[T]he state fined USA Healthcare nursing home in Urbandale \$13,400 last year after threatening to pull the home’s license because of widespread physical abuse and neglect of the elderly residents. Medicaid funding for the home was shut off and dozens of senior were forced to move.

This year, the owners are expected to collect \$76,859 in performance-based Medicaid bonuses from the state and federal governments.

* * *

Last year, the Department of Inspections and Appeals fined the Lutheran Home Society care facility in Muscatine \$7,000 for dozens of alleged health and safety violations. The home’s license was placed on restricted status; federal officials imposed additional fines, and Medicaid funding for new residents was temporarily cut off.

But this year the Muscatine nursing home’s owners can expect to collect \$115,188 in bonuses from the Medicaid program. That’s because the home scored points for its high occupancy rate, its admission of Medicaid-dependent residents and its low administrative costs.

Two of the Iowa facilities scheduled to receive bonuses were on the federal government’s Special Focus Facility list.

In a companion article, *The Des Moines Register* identified 23 facilities that were fined \$10,000 or more in 2007, 16 of which were expected to collect bonus payments in 2008. Clark Kauffman, “Nursing home fines and bonuses,” *The Des Moines Register* (March 2, 2008). For 10 of the 16 facilities receiving bonuses, the bonus exceeded the fine.

Facility	2007 State Fine	2008 Medicaid Bonus
Iowa Masonic Home, Bettendorf	\$15,000	\$44,502
USA Healthcare, Urbandale	\$13,400	\$76,859
Park View Care Center, Burlington	\$12,250	\$22,418
Woodlands Rehabilitation Center, Council Bluffs	\$12,000	\$33,801
Good Samaritan Home, Villisca	\$11,500	\$25,198
Nelson Nursing Home, Fairfield	\$11,500	\$17,972
Windmill Manor, Coralville	\$10,500	\$24,811
The Manor, Malvern	\$10,350	\$18,555
Clearview Home, Mount Ayr	\$10,000	\$57,552
Elm Crest Retirement Community, Harlan	\$10,000	\$24,142

Although *The Des Moines Register* was investigating the incentive program, similar concerns apply to “facility improvement initiatives.”

CMS should issue guidance making facilities ineligible for “facility improvement initiative” payments if they have certain numbers or levels of deficiencies, or both. Poorly-performing facilities need to focus their attention on attaining and maintaining compliance with the Requirements of Participation. This concern is reinforced by a study of culture change in nursing facilities owned and operated by Beverly Enterprises, which found that facilities with poor compliance histories are not “the best” candidates for culture change. Leslie A. Grant, *Culture Change in a For-Profit Nursing Home Chain: An Evaluation*, page 3 (Feb. 2008), http://www.commonwealthfund.org/usr_doc/Grant_culturechange4for-profitnursinghome_1099.pdf?section=4039. The study reports as the first of three “Early Lessons Learned”:

Facilities with poor histories of state-survey compliance were not the best candidates for culture change. Successful facilities tended to have better compliance histories in meeting state and federal regulatory standards. But if a facility had significant problems with compliance, regulatory issues tended to take precedence over everything else; the RCC initiative there was not considered critical to the organization’s survival or core mission.

Report 3.

g. We recommend that any joint surveyor/provider training include consumer representatives. CMS also needs to provide guidance on, and should require specific CMS approval for, programs of joint training of surveyors and facility staff. In all such joint training, consumers must be included; no joint surveyor/facility training should exclude consumer representatives. Survey agencies must also retain full authority to identify which trainings they will invite providers and consumers to attend; some trainings should continue to be open only to survey personnel.

In response to CMS’s specific question on page 39647, we oppose allowing CMP funds to be used to offset some of the costs of IIDR, for the reasons discussed above. Facilities should be required to bear the full additional costs of IIDR since they already have the option of IDR, at no additional cost to them. The only exception should be the costs of ombudsman/families/advocates who are submitting written information to the IIDR; their costs could be allowable from federal CMP funds.

h. Most importantly, we strongly recommend that CMS convene a workgroup of interested organizations to discuss the guidance for use of CMPs for facility projects. The workgroup needs to define “culture change” and which types of culture change programs and projects would be eligible for CMP funding. The workgroup should also identify which categories of projects would be eligible for funding automatically and which would require case-by-case review. Guidance also needs to establish which facilities are categorically ineligible for CMP funds because of their poor performance. These are complex questions that need further discussion and debate before CMS issues its guidance document. In June 2009, CMS recognized the confusion about CMPs and the complex issues surrounding their use. See “Use of Civil Money Penalty (CMP) Funds by States and Reporting of CMP Funds Returned to the State,” S&C-09-44 (June 19, 2009). More discussion is needed before this important new provision is implemented.

Additional Recommendations

To further strengthen the CMP remedy, we make the following additional recommendations:

1. CMS should request legislative authority to increase the amounts of the CMPs. The amounts were set by regulation in 1994 and have not been increased since. The Reform Law should be amended (1) to adjust CMPs to reflect inflation since 1994 and (2) to authorize automatic adjustments each year to reflect the consumer price index.

The California State Auditor observed in a recent report that federal CMPs have not been increased in 15 years and that application of inflation adjustments would have increased federal penalties by about 50% (upper level penalties would increase from \$3050-\$10,000 to \$4363-\$14,305). California State Auditor, *Department of Public Health: It Reported Inaccurate Financial Information and Can Likely Increase Revenues for the State and Federal Health Facilities Citation Penalties Accounts*, Report 2010-108, pages 35-36 Table 3 (June 2010), <http://www.bsa.ca.gov/pdfs/reports/2010-108.pdf>.

2. CMS should provide guidance to Administrative Law Judges that they have authority to increase the amount or duration, or both, of the CMP during an administrative appeal.

At present, ALJs sometimes decrease the amount of a CMP, particularly if they reject some of the resident examples or some deficiencies. *See, e.g., Rensselaer Care Center v. CMS*, CR1944 (May 4, 2009), <http://www.hhs.gov/dab/decisions/civildecisions/cr1944.pdf>, where the ALJ rejected two of four residents identified in a supervision deficiency and reduced the per day CMP from \$400 to \$200.

We have never seen an instance where an ALJ has increased the daily amount of a CMP, even when acknowledging that the amount is low.

In *Mission Oaks Manor v. CMS*, CR2102 (April 1, 2010), <http://www.hhs.gov/dab/decisions/civildecisions/cr2102.pdf>, the ALJ sustained two per instance CMPs, each \$5000, for three deficiencies involving physical restraints and neglect and including the death of one resident. The ALJ described the CMPs as “extraordinarily modest considering what CMS might have imposed.” Decision 24. She noted the facility’s history of noncompliance – the facility was in its ninth cycle of noncompliance and the enforcement action was the second since October 2004. She rejected the facility’s claim that the CMP was a significant financial burden, writing, “Of course, the burden should be ‘significant’ or it is not likely to produce corrective action,” and found a significant degree of culpability, particularly with respect to R13 [who died], which made the CMPs “seem minimal.” *Id.* Nevertheless, she did not increase the CMPs.

We have not seen an example of an ALJ’s extending the duration of a CMP, even when they recognize that the CMP could have started much earlier. For example, in *The Lodge at Maplecreek v. CMS*, CR2110 (April 12, 2010), <http://www.hhs.gov/dab/decisions/civildecisions/cr2110.pdf>, the ALJ sustained a per day jeopardy-

level CMP of \$5250 for one day for an abuse deficiency, even though “CMS could have – but elected not to impose a civil money penalty of at least \$3050 per day for each day of the period beginning in November 2008 and continuing through the April survey,” which, the ALJ noted, “would have dwarfed the amount that CMS determined to impose here.”

3. We recommend that CMS convene a workgroup to review the GAO reports that have been issued about the nursing home enforcement system since July 1998. GAO reports over the past 12 years have consistently and repeatedly documented the need for stronger enforcement of the Nursing Home Reform Law. CMS should review and implement the many thoughtful recommendations of the reports through, as appropriate, Notice of Proposed Rulemaking, informal guidance, and surveyor training.

GAO reports:

Nursing Homes: Some Improvement Seen in Understatement of Serious Deficiencies, but Implications for the Longer-Term Trend Are Unclear. GAO-10-434R. Washington, D.C.: April 28, 2010.

Federal and state governments share responsibility for ensuring that nursing homes provide *Nursing Homes: Addressing the Factors Underlying Understatement of Serious Care Problems Requires Sustained CMS and State Commitment.* GAO-10-70. Washington, D.C.: November 24, 2009.

Nursing Homes: Opportunities Exist to Facilitate the Use of the Temporary Management Sanction. GAO-10-37R. Washington, D.C.: November 20, 2009.

Nursing Homes: CMS’s Special Focus Facility Methodology Should Better Target the Most Poorly Performing Homes, Which Tended to Be Chain Affiliated and For-Profit. GAO-09-689. Washington, D.C.: August 28, 2009.

Medicare and Medicaid Participating Facilities: CMS Needs to Reexamine Its Approach for Funding State Oversight of Health Care Facilities. GAO-09-64. Washington, D.C.: February 13, 2009.

Nursing Homes: Federal Monitoring Surveys Demonstrate Continued Understatement of Serious Care Problems and CMS Oversight Weaknesses. GAO-08-517. Washington, D.C.: May 9, 2008.

Nursing Home Reform: Continued Attention Is Needed to Improve Quality of Care in Small but Significant Share of Homes. GAO-07-794T. Washington, D.C.: May 2, 2007.

Nursing Homes: Efforts to Strengthen Federal Enforcement Have Not Deterred Some Homes from Repeatedly Harming Residents. GAO-07-241. Washington, D.C.: March 26, 2007.

Nursing Homes: Despite Increased Oversight, Challenges Remain in Ensuring High-Quality Care and Resident Safety. GAO-06-117. Washington, D.C.: December 28, 2005.

Nursing Home Quality: Prevalence of Serious Problems, While Declining, Reinforces

Importance of Enhanced Oversight. GAO-03-561. Washington, D.C.: July 15, 2003.

Nursing Homes: Sustained Efforts Are Essential to Realize Potential of the Quality Initiatives. GAO/HEHS-00-197. Washington, D.C.: September 28, 2000.

Nursing Home Care: Enhanced HCFA Oversight of State Programs Would Better Ensure Quality. GAO/HEHS-00-6. Washington, D.C.: November 4, 1999.

Nursing Homes: Proposal to Enhance Oversight of Poorly Performing Homes Has Merit. GAO/HEHS-99-157. Washington, D.C.: June 30, 1999.

Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards. GAO/HEHS-99-46. Washington, D.C.: March 18, 1999.

California Nursing Homes: Care Problems Persist Despite Federal and State Oversight. GAO/HEHS-98-202. Washington, D.C.: July 27, 1998.

Thank you for the opportunity to comments on the proposed regulations.

Sincerely,

Toby S. Edelman

Submitted by the Center for Medicare Advocacy on behalf of itself and

California Advocates for Nursing Home Reform
National Senior Citizens Law Center

California Advocates for Nursing Home Reform

Since 1983, California Advocates for Nursing Home Reform (CANHR), a statewide nonprofit 501(c)(3) advocacy organization, has been dedicated to improving the choices, care and quality of life for California's long term care consumers. Through direct advocacy, community education, legislation and litigation, it has been CANHR's goal to educate and support long term care consumers and advocates regarding the rights and remedies under the law, and to create a united voice for long term care reform and humane alternatives to institutionalization.

National Senior Citizens Law Center

The National Senior Citizens Law Center (NSCLC), a non-profit organization in its 35th year, advocates nationwide to promote the independence and well-being of older Americans and those with disabilities, particularly those with limited financial resources. NSCLC focuses in large part on two fundamental issues facing older Americans and people with disabilities: maintaining a basic level of income and having access to adequate health care. As part of this focus, NSCLC advocates on behalf of nursing home residents for a better quality of care and for adequate coverage of nursing home expenses. Much of NSCLC's nursing home advocacy relates to Medicare and Medicaid financing of nursing home services.

Center for Medicare Advocacy

Center for Medicare Advocacy is a private, non-profit organization, founded in 1986, that provides education, analytical research, advocacy, and legal assistance to help elders and people with disabilities obtain necessary healthcare. The Center focuses on the needs of Medicare beneficiaries, people with chronic conditions, and those in need of long-term care. The Center provides training regarding Medicare and health care rights throughout the country and serves as legal counsel in litigation of importance to Medicare beneficiaries nationwide.