**Briefing Paper**

**Why Were One-Third of SNF Patients in the Inspector General’s Study Harmed?**

An Office of Inspector General study, *Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries* (February 2014), found that one-third of residents who were in a skilled nursing facility (SNF) for short-term care were harmed, and that almost 60 percent of the injuries were preventable and attributable to poor care. As a result, six percent of those who were harmed died, and more than half were rehospitalized at an annualized cost of $2.8 billion in 2011. Why is the rate of substandard care so high in nursing homes?

**Reimbursement Was Not to Blame – Medicare Payments Were Unusually High**

MedPAC reported that SNF reimbursement rates were unusually high in 2011, the year of the OIG study: “Increases in payments between 2010 and 2011 outpaced increases in providers’ costs, reflecting the continued concentration of days in the highest payment case-mix groups. In addition, payments in 2011 were unusually high because of overpayments resulting from an adjustment made to implement the new case-mix groups. Because Medicare cost reports were not available in time for this report, we estimated a range for the 2011 margins: from 22 percent to 24 percent. This year is the 11th year in a row with Medicare margins above 10 percent.” – MedPAC: *Report to the Congress, Medicare Payment Policy*, March 2013, Chapter 8, Skilled nursing facility services. [The actual margin, reported in MedPAC’s March 2014 report to Congress, was 21 percent.]

**States Are Less Likely to Cite Nursing Homes for Seriously Harming Residents**

The percentage of nursing homes cited for actual harm or jeopardy to residents fell from 24.8 percent in 2003 to 21.9 percent in 2011, the year the OIG found that one-third of SNF residents experienced adverse events. (<http://kff.org/other/state-indicator/of-facilities-w-serious-deficiencies/#graph>)

**Nursing Homes Are Rarely Cited for Understaffing**

Among preventable events analyzed by the OIG, the majority were attributed to failure to monitor residents adequately or to provide necessary treatments. Yet very few facilities (.022 percent in 2013) are cited for staffing deficiencies. Moreover, almost 94 percent of staffing deficiencies that were cited in 2010 were classified as causing “no harm,” and in the whole country in 2013, only three nursing homes were cited for placing residents in jeopardy because of insufficient staff. See <http://www.medicareadvocacy.org/staffing-deficiencies-in-nursing-facilities-rarely-cited-seldom-sanctioned/>.

**Enforcement Has Dropped Dramatically**

Federal enforcement remedies dropped dramatically between 2007 and 2012, from 4,836 to 3,152. (<http://www.ltccc.org/news/documents/EnforcementTrends--2007-2013-June2013.xls>). Between 2011 and 2013, federal fines and denials of payment for new Medicare and Medicaid admissions fell over 40 percent—from 3,312 to 1,909—according to Nursing Home Compare in March 2014. (Data are updated at [data.medicare.gov/d/2shu-hjj2](http://data.medicare.gov/d/2shu-hjj2).)

**CMS Partnerships with Providers Are Ineffective, Cause Conflicts of Interest**

In its seminal study of nursing home regulation in 1986, the blueprint for the 1987 Nursing Home Reform Law, the Institute of Medicine recommended separation between the consulting and regulatory roles of survey agencies: “The compliance-oriented consulting role . . . can lead surveyors to be too understanding and lenient toward substandard providers. [It] may allow surveyors to work with a facility for long-range improvements, but . . . threats of punishment are not credible if they are not used predictably under specified circumstances.”

The Department of Health and Human Services ignored this principle when it transferred survey and certification to the Center for Clinical Standards and Quality, subordinating its regulatory functions to technical assistance and quality improvement. The results are evident in the Partnership to Improve Dementia Care in Nursing Homes, where CMS set a minimal goal to reduce antipsychotic drug use by 15 percent by December 2012. CMS did not step up enforcement when nursing homes had not met the goal by December 2013 but continued its campaign to reduce the illegal drugging of only a fraction of the 300,000 residents who are at risk of somnolence, serious medical problems, and death.

**CMS Portrays Inspections As Collaborations with Nursing Homes**

CMS has a *Provider Welcome* statement on its Surveyor Training website that encourages nursing homes to expect consultative surveys: “CMS wants providers to understand the purpose and process of survey and certification. The S&C process is a collaborative effort between CMS and providers to ensure Medicare and Medicaid beneficiaries are receiving quality health care.”

(<http://surveyortraining.cms.hhs.gov/pubs/ProviderWelcome.aspx>)

**Quality Management Approaches Have Not Proven Their Value in Nursing Homes**

CMS’s response to the shocking data in the OIG study was not to improve enforcement but rather to say it would address serious incidents through Quality Assurance and Performance Improvement programs. Such programs have little track record of success in nursing homes. For example, a 2009 OIG study, *Nursing Home Corporations under Quality of Care Corporate Integrity Agreements*, found that most chains had more substandard quality of care deficiencies during and following the period they carried out intensive quality assurance programs to avoid termination from Medicare and Medicaid.

**CMS Does Not Provide Reliable Staffing Information Required by Law**

CMS spent thousands of staff and contractor hours over more than a decade to develop a system, now required by the Affordable Care Act, to improve the reliability of its nursing home staffing data and accuracy of its Five Star Quality Ratings. Yet, CMS stopped work on the system after pilot tests in 2012. As a result, the public is at increased risk of entering a nursing home with substandard staffing, and hospitals continue to discharge patients to facilities that do not have the nursing capacity to avoid adverse events.

**CANHR (California Advocates for Nursing Home Reform); Center for Medicare Advocacy; Long Term Care Community Coalition; National Consumer Voice for Quality Long-Term Care**