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ONE HUNDRED TENTH CONGRESS

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May 14, 2008

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MEMORANDUM

TO: Subcommittee on Oversight and Investigations Members and Staff

FROM: Committee on Energy and Commerce Staff

SUBJECT: May 15, 2008, Hearing entitled, "In the Hands of Strangers: Are Nursing Home Safeguards Working?"

On Thursday, May 15, 2008, at 10:00 a.m. in room 2123 Rayburn House Office Building, the Subcommittee on Oversight and Investigations will hold a hearing entitled, "In the Hands of Strangers: Are Nursing Home Safeguards Working?" This hearing, which is being held during "National Nursing Home Week," is the first in a series that the Subcommittee plans to hold on long-term care financing and quality-of-care issues.

BACKGROUND

More than 1.7 million elderly and disabled Americans will receive care this year in approximately 17,000 nursing homes certified by Medicare and Medicaid. Some of these patients will be long-term nursing home residents, while others will have shorter stays for rehabilitation or post-acute care after hospitalization. Federal, State, and local governments pay for more than 62.5 percent of all nursing home residents' care. The Centers for Medicare and Medicaid Services (CMS) estimated that government spending on nursing home care in 2006 exceeded \$78.1 billion (not including Federal spending related to nursing home care under Medicare Parts B, C, and D). With the aging of the baby boom generation, the number of individuals needing nursing home care, and the associated costs, are expected to increase dramatically, particularly as consumer expectations for improved service rise.

When Congress enacted the Nursing Home Reform Act (as part of the Omnibus Budget Reconciliation Act of 1987 or "OBRA 87"), the Federal Government assumed a more central role in ensuring that the highly vulnerable population in the country's nursing homes will receive appropriate care. OBRA 87 established a comprehensive framework of quality-of-care and quality-of-life requirements that nursing homes must meet to participate in the Medicare and Medicaid programs. CMS enforces these standards by contracting with States to inspect homes routinely and to conduct complaint investigations through "surveys." In an effort to correlate

enforcement remedies to the scope and severity of problems identified, OBRA 87 established graduated sanctions, ranging from civil money penalties (CMPs) to the rarely-used, ultimate sanction of termination from participation in the Medicare and Medicaid programs.

While progress has been made in some quality areas since OBRA 87 (e.g., a reduction in the use of physical restraints), many of the problems that gave rise to the original legislation persist. Numerous studies by the Government Accountability Office (GAO), the Office of the Inspector General for the Department of Health and Human Services (HHS-OIG), and independent researchers uniformly report that a significant subset of the Nation's nursing homes persistently fail the residents in their care. A recent GAO report found, for instance, that almost one in five nursing homes was cited in the prior fiscal year for serious deficiencies—*violations that caused actual harm or placed residents in immediate jeopardy*.¹

Nursing homes with serious quality problems continue to cycle in and out of compliance, causing residents to suffer needlessly from malnutrition, dehydration, pressure sores, uncontrolled pain, physical and sexual abuse, and even death. Authorities also repeatedly point to a weak enforcement system under which State inspectors often fail to identify serious violations and, when they do, they tend to underrate the scope and severity of the problem, which then translates into low-level sanctions largely viewed as a cost of doing business.

The nursing home industry has gone through a tumultuous two decades and is continuing to evolve rapidly. In the years leading up to the implementation of a prospective payment system for nursing homes under the Balanced Budget Act of 1997, the industry expanded into large national, publicly-held chains in response to policy, demographic, and market incentives. Today, more than half of all nursing homes are part of a chain.² In the late 1990s, many of the larger chains found themselves over-leveraged and filed for reorganization under Chapter 11.³

As they emerged from bankruptcy, the chains began to focus more on specific geographic markets, in many cases, expanding their case mixes to emphasize more lucrative Medicare reimbursements for post-acute and rehabilitation care. At the same time, they reduced long-term care services reimbursed through the much lower-paying Medicaid programs.⁴ Others developed ancillary and complementary business lines such as physical therapy and other services reimbursable under Medicare Part B, medical equipment supply companies, and even pharmaceuticals, now reimbursable under Medicare Part D.⁵

¹ GAO, *Nursing Homes: Efforts to Strengthen Federal Enforcement Have Not Deterred Some Homes from Repeatedly Harming Residents*, GAO-07-241 (Washington, D.C.: March 2007).

² David Stevenson, David Grabowski, and Laurie Coots, *Nursing Home Divestiture and Corporate Restructuring: Final Report*. (Washington, D.C., U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation and Office of Disability, Aging and Long-Term Care Policy, December 2006), p. iii.

³ By 2000, five of the seven largest nursing home operators were in bankruptcy protection (Beverly and Manor Care remained solvent). GAO, *Skilled Nursing Facilities -- Medicare Payments Exceed Costs for Most but Not All Facilities*. GAO-03-183. (Washington, D.C.: December 2002).

⁴ Medicare will pay, for instance, approximately \$450 per day for some patients qualifying for post-acute care, while Medicaid rates for long-term care can average \$120 per day in some States.

⁵ For instance, according to its Web site, one of the witnesses at the hearing, UHS-Pruitt Corporation, currently manages, "through affiliates, 56 nursing homes, four personal care centers, a management company, three pharmacies, a hospice with eight offices and a separate inpatient unit, a care management company, four certified home health agencies, seventeen real estate companies, a transportation company, Part B Enteral and Parent[er]al Billing Company and food and linen company." In addition, UHS-Pruitt affiliates are collectively one of the largest providers for long-term veterans' services in the Southeast.

<http://www.uhs-pruitt.com/AboutUs/History/tabid/328/Default.aspx>.

Private equity firms began showing increased interest in the nursing home market in 2002, principally as lucrative real estate investments. These new investors increased their purchases of the regional portions of publicly-held chains through leveraged-buyout deals, typically using Real Estate Investment Trusts (REITs) or limited liability partnerships to acquire and mortgage each facility property (i.e., “monetizing the real estate”), then entering into sale leaseback arrangements with the facilities.

They frequently created separate corporate entities to operate each facility, whose assets are largely comprised only of the facility’s accounts receivable. Each real estate and operating entity is, in turn, owned by multiple tiers of limited liability corporations, limited liability partnerships, and/or REITs intended to serve as corporate firewalls between a facility’s day-to-day operations and those who receive income from the investment and/or a return on the investment when the chain is sold. In some instances, the leaseback terms may limit facility operators’ authority to hire staff or make capital expenditures over certain amounts. These elaborate corporate structures are largely designed to maximize profit and insulate the investment assets from liability for poor care.⁶

The impact of these newer investors and the new financial structures on care delivery and quality is still unclear. It is of some concern that many of the recent profitability strategies focus on maximizing the number of higher acuity patients—those who need higher numbers of skilled staff to care for them—while staffing levels at most chains appear to remain static.

What is certain, however, is that CMS and the States, as regulators, are ill-equipped to deal with these new models. From the beginning, CMS’s survey and enforcement system was never designed to identify chain-wide or systemic problems. Moreover, while Medicare institutional providers generally must supply information concerning the sale of the provider itself (i.e., the facility *operator*), they are not required to disclose much, if any, information to CMS, or State licensing agencies, concerning nursing home property ownership, mortgage, or affiliated party or self-referral relationships. The challenges posed by complex corporate structures are even greater for consumers, their families and resident advocates (such as local ombudsmen) seeking protection for individual patients.

The purpose of this hearing is to examine: a) how Federal and State enforcement of Federal quality-of-care standards can protect nursing home residents in all nursing homes; and b) whether the new financial models for nursing home chains warrant new approaches to quality enforcement. Key issues include:

- Do more opaque, multi-tiered ownership structures undermine the ability of regulators to identify parties accountable and protect nursing home residents from harm?
- Can CMS track changes of ownership and control of nursing home chains and identify systemic quality problems in a chain?

⁶ A number of chains also have elected to “go bare” (i.e., carry no liability insurance) or maintain extremely low insurance coverage as a way to prevent or discourage litigation. In some States such as Florida, however, insurance options are limited because a number of carriers have chosen to withdraw from the market.

- Where systemic problems originate from limitations imposed by the owners, operators, or financiers of a chain of facilities, can CMS identify and correct problems on a chain-wide basis?
- Is it possible to reduce subjectivity in the survey system and improve the identification of significant problems in facilities through the Quality Indicator Survey (QIS)? Why is the implementation of QIS behind schedule?
- Can CMS's Special Focus Facility (SFF) program improve chronic poor performers that have consistently caused harm to residents? Should CMS expand the program substantially to address the much larger percentage of chronic poor performers that continue to operate?

THE SURVEY AND ENFORCEMENT SYSTEM

The major provisions of OBRA 87 included a residents' bill of rights, specific standards for the delivery of care, and a strengthened enforcement framework.⁷ Although consumer advocates pushed for a specific minimum staff-to-resident ratio in the OBRA 87 legislation because of the well-established linkage between quality of care and staffing levels, the final language required only that nursing homes have "sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care."⁸ While OBRA 87 was intended to compel immediate quality improvements in nursing homes, its full enforcement was delayed until final regulations were promulgated in 1995.

States must inspect every facility in the State once a year—and no later than within 15 months of the prior survey—via an unannounced survey in order to certify the facility for continued participation in Medicare and Medicaid. Problems uncovered by surveyors, called "deficiencies," are categorized (on a "grid") according to their scope and severity, which indicates the extent to which they jeopardize one or more residents' health or well-being.

After a survey, facilities must submit a "plan of correction" to CMS and/or the State survey agency for approval, unless the survey has identified only isolated deficiencies. If a facility does not correct the deficiencies and achieve substantial compliance within three months, then CMS has the option to deny payment for new admissions to the facility. "Substantial compliance" is defined as a condition where the remaining problems pose "no greater risk to resident health or safety than the potential for causing minimal harm."

CMS authority to impose remedies for violations arises out of the Medicare provider agreements with the individual facilities. As a result, CMS administrative enforcement actions apply only to the operator of a single facility, not to a chain, or the investors or owners of a large

⁷ Codified at 42 U.S.C. §§ 1395i-3(a)-(h), 1396r(a)-(h) (1988). OBRA 87 requires, among other things, a thorough assessment of each resident's functional capacity, to be used in developing a written care plan; specialized rehabilitation; a requirement that homes use less restrictive measures before turning to physical restraints; and a prohibition against "unnecessary" drugs. The statute requires providers to ensure that each resident achieves and maintains the "highest practicable physical, mental, and psychosocial well-being."

⁸ 42 C.F.R. § 483.30. Other minimum requirements, which can be waived by the State, include that the facility must use the services of a registered professional nurse at least 8 consecutive hours a day, 7 days a week with a minimum of 8 hours per day. *Id.*

nursing home corporation. When the problems at the facility derive from decisions made by distant owners, investors, or financiers, the scope and effectiveness of a facility-specific remedy is significantly limited. Moreover, an enforcement action that, for instance, forces chain owners to increase staffing or resources at one of its facilities may leave similar problems unaddressed at others. Thus, improvements at one facility may occur at the expense of sister facilities losing essential resources or staffing.

Evaluations of the effects of OBRA's regulations on quality of care reveal mixed results. For example, consistent with the law's intent, the use of *physical restraints* on residents was cut in half between 1994 and 2004.⁹ At the same time, the use of atypical antipsychotics appears to have increased substantially, thus subjecting residents to greater *chemical restraints* and exposing them to new health risks from potential adverse reactions to these medications.¹⁰ Throughout the 1990s and 2000s, a series of other quality measures displayed mixed results. For example, the number of deficiencies per certified nursing facility has increased, while several post-acute care quality measures have improved.¹¹

Despite OBRA 87's attempt to set specific and uniform quality standards, surveys are administered inconsistently and tend to be overly subjective. Variations in management, resources, staff turnover, and informal standards at the local surveyor office and the State level lead to wide variations in how "aggressive" nursing home surveyors will be during inspections. The result is that relatively good homes may be cited and fined for violations, while lower quality homes escape the survey unscathed.

Underreporting of Deficient Care

In a study commissioned by CMS, the University of Colorado Health Sciences Center found that surveyors systematically downgrade findings of deficiency in nursing homes (the Kramer Report).¹² Although the Kramer Report was submitted to CMS last March, to date CMS has not publicly released it. The Kramer Report concluded that, while surveyors were diligent in conducting surveys and fair in their approach, the survey system identified *only 25 percent of deficient practices in a facility*.¹³ Importantly, errors were always in the direction of failing to identify deficiencies, rather than falsely identifying deficiencies. Moreover, the report revealed that those deficiencies that surveyors did identify were *downgraded in 56 percent of all cases*.¹⁴ That is, even when surveyors detected violations of Federal regulations, they tended to treat the violations less seriously than the regulations require, resulting in correspondingly lower penalties or no penalties at all.

⁹ Charlene Harrington, Helen Carrillo, and Brandee Wolessagle Blank, *Nursing Facilities, Staffing, Residents and Facility Deficiencies, 1994 Through 2000* (San Francisco: Department of Social and Behavioral Science, University of California, 2001); Harrington, *et al.*, series 2001–2007.

¹⁰ Becky A. Briesacher, M. Rhona Limcangco, Linda Simoni-Wastila, Jalpa A. Doshi, Suzi R. Levens, Dennis G. Shea, and Bruce Stuart, "The quality of antipsychotic drug prescribing in nursing homes," *Archives of Internal Medicine*, Vol. 165, No. 11 (2005): 1280-1285; and Rosa Liperoti, Vincent Mor, Kate L. Lapane, Claudio Pedone, Giovanni Gambassi, and Roberto Bernabei, "The use of atypical antipsychotics in nursing homes," *Journal of Clinical Psychiatry*, Vol. 64, No. 9 (2003): 1106–1112.

¹¹ Joshua M. Wiener, Marc P. Freiman, and David Brown, *Nursing Home Quality: Twenty Years After the Omnibus Budget Reconciliation Act of 1987* (Washington, D.C., Kaiser Family Foundation, December 2007).

¹² Helena Louwe, Carla Parry, Andrew Kramer, and Marvin Feuerberg, *Improving Nursing Home Enforcement: Findings from Enforcement Case Studies* (Aurora, CO: University of Colorado Health Sciences Center, March 22, 2007).

¹³ Louwe *et al.*, *op. cit.*, p. 13, Table. 3.

¹⁴ Louwe *et al.*, *op. cit.*, p. 19.

The New Quality Indicator Survey (QIS)

One of the more promising survey tools is the Quality Indicator Survey, which reflects an attempt to standardize the survey process, increase consistency, and establish better vehicles for State and Federal oversight. QIS is a two-stage, computer-assisted process. Surveyors interview residents and family members during the first stage and collect quality of care data, assisted by a laptop computer “tablet” with interview prompts and the ability to compare the findings to national norms in real time. The second stage is a systematic investigation of the problem areas identified in the first stage. Nursing homes may directly benefit from using stage two for their own internal quality assurance and monitoring.

CMS launched a five-State demonstration of QIS in the fall of 2005 that included parts of California, Connecticut, Kansas, Louisiana, and Ohio. In the fall of 2007, CMS began statewide implementation of QIS in Connecticut, and in parts of Florida, Kansas, Ohio, Louisiana, and Minnesota. Unfortunately, the timeline for implementation in additional States is already far behind schedule, principally because of limitations on CMS funding for State surveyor agencies. CMS’s original plan called for a five-year rollout. At the present rate, complete implementation would take CMS approximately 10 to 15 years.

The idea behind QIS is well regarded in Government circles, in the industry, among nursing home staff, and by academics who study nursing home quality. Numerous surveyors have commented that QIS helps them get closer to the heart of the real issues facing homes.¹⁵

Nonetheless, an early evaluation (also commissioned by CMS and unreleased) questions whether QIS is superior to traditional surveys in terms of surveyor accuracy or efficiency.¹⁶

The Special Focus Facility (SFF) Program

The SFF Program was created in 1999 as part of an initiative to improve the most poorly performing nursing homes.¹⁷ CMS identifies potential SFF candidates in each State based on facility histories of citations for actual harm over the preceding 3 years. Due to the substantial Federal resources involved in helping an SFF facility come into compliance, CMS limits States to selecting only a few facilities to participate.¹⁸ There are currently 134 facilities on the SFF list. Using GAO’s estimate that 20 percent of homes are chronic poor performers, SFF facilities represent less than 1 percent of the 3,400 potential candidates.

¹⁵ Andrew M. Kramer, “Quality Indicator Survey Demonstration: The Big Picture,” Chapter 8 in Alan Qhite, Jack Schnelle, Rosanna Bertrand, Kelley Hickey, Donna Hurd, David Squires, Rebecca Sweetland, and Terry Moore, *Evaluation of the Quality Indicator Survey (QIS)*, Contract #500-00-0032, TO#7 (Baltimore, MD, CMS, December 2007).

¹⁶ Alan Qhite, Jack Schnelle, Rosanna Bertrand, Kelley Hickey, Donna Hurd, David Squires, Rebecca Sweetland, and Terry Moore, *Evaluation of the Quality Indicator Survey (QIS)*, Contract #500-00-0032, TO#7 (Baltimore, MD, CMS, December 2007).

¹⁷ Until April 2008, CMS had resisted publicizing information about the identity of Special Focus Facilities. Indeed, some SFFs themselves reportedly did not know they were on the list. In April, CMS decided to add the SFF list to its Survey and Compliance Web site, http://www.cms.hhs.gov/certificationandcompliance/12_nhs.asp. Centers for Medicare and Medicaid Services, *Critical New Information Added to Nursing Home Compare Web Site* (Washington, DC: CMS Public Affairs, April 24, 2008).

¹⁸ GAO, *Nursing Homes: Federal Actions Needed to Improve Targeting and Evaluation of Assistance by Quality Improvement Organizations*, GAO-07-373 (Washington, D.C.: May 2007) (GAO QIO Report).

SFFs are supposed to undergo thorough inspections every 6 months, but recent reports suggest that CMS and the States can only survey 41 percent of SFFs within that timeframe. Facilities must make significant improvements within 18 months to “graduate” from the list or face termination from the Medicare program.¹⁹ CMS’s most recent report indicates that 6 facilities failed to “graduate” and are no longer participating in Medicare or Medicaid programs, while 15 facilities have graduated off the list.

One limitation on the effectiveness of the SFF program is the competence and availability of CMS-funded Quality Improvement Organizations (QIOs) in each State. Although SFFs may seek assistance from a QIO, many SFFs fail to do so and many QIOs do not volunteer to work with underperforming facilities. GAO found that QIOs generally targeted facilities based on their likelihood of rapid improvement rather than the types of problematic homes that are SFFs.²⁰ In its 2008 nursing home action plan, CMS proposes to direct QIOs to work with SFFs on a more consistent basis.

Enforcement Sanctions Do Not Deter Harm to Residents

When nursing homes are found to be noncompliant with Federal regulations, they may be subject to a variety of penalties depending on the scope and severity of violation, including: (1) a detailed plan of correction; (2) State monitoring; (3) directed in-service training; (4) denial of payments for new admissions (or for all individuals); (5) civil money penalties (CMPs); (6) temporary management; or (7) termination.²¹ CMPs are the most commonly imposed penalties among enforcement cases referred to CMS, being imposed in about 50 percent of all cases.²²

As currently used, CMPs have little deterrent effect on nursing homes with serious problems. According to HHS-OIG, “CMS does not utilize the full dollar range allowed for CMPs” and tends to impose fines at the lower end of the continuum.²³ Close examination of these fines raises serious questions about whether the punishment fits the crime. For example, a case of failure of supervision leading to the strangulation death on a bedrail was fined only \$4,050, while failure to follow physician’s treatment orders leading to a leg amputation was fined only \$7,500.²⁴ Moreover, when penalties are imposed, justice is often delayed egregiously, with one study showing that 54 percent of cases took more than 1 year to resolve.²⁵ Studies also have shown that the length of time and the staff resources involved for surveyors to defend deficiencies against facility appeals are a disincentive for surveyors to cite homes in the first place.²⁶

¹⁹ CMS, *Special Focus Facility (“SFF”) Initiative* (Washington, D.C. CMS, April 2008). On-line: <http://www.cms.hhs.gov/CertificationandCompliance/Downloads/SFFList.pdf>, accessed April 25, 2008.

²⁰ GAO QIO Report.

²¹ Inspector General, *Nursing Home Enforcement: The Use of Civil Money Penalties*, OEI-06-02-00720 (Washington, D.C. Department of Health and Human Services, Office of the Inspector General, April 2005), p. 5. On-line: <http://www.oig.hhs.gov/oei/reports/oei-06-02-00720.pdf>, accessed April 27, 2008.

²² Inspector General, *op. cit.*, p. 6.

²³ Inspector General, *op. cit.*, p. ii.

²⁴ Toby Edelman, *Nursing Home Decisions of the Departmental Appeals Board, 2007* (Washington, D.C. Center for Medicare Advocacy, April 2008), p. 1.

²⁵ Edelman, *op. cit.*, p. 16.

²⁶ Louwe *et al.*, *op. cit.*, p. 25.

Regulating Chains

Almost 20 years after the industry began to tip toward dominance by chains, CMS still does not have the ability to observe and correct problems that are common within a single chain. Sarah Slocum, the Michigan State Long Term Care Ombudsman, shared a concrete example of this problem in her testimony before the U.S. Senate Special Committee on Aging. She reported:

During 2005, two nursing facilities burned in Michigan. One resulted in 2 deaths and partial facility evacuation during the Easter holiday weekend. The other resulted in 2 resident deaths and 60 residents sent to the hospital along with complete evacuation in mid-December. There was no overt connection between these two facilities (such as the same name) and it took considerable effort by the Ombudsman to learn of their common management company. Despite different owners of the real estate, the management and operations of the two facilities were run by the same people. In both cases, inadequate staff training contributed to resident harm.²⁷

While fire safety was at issue in this example from Michigan, a wide range of quality care problems often result from similar ownership structures. Inadequate staffing, unnecessary restraint of residents, and patients suffering from pressure ulcers—to name only a few potential problems—may all follow from common management deficiencies throughout a chain.

Scott A. Johnson, the Special Assistant Attorney General of the State of Mississippi, notes that regulators often find themselves “pointing the finger at ghosts” when ownership structures are disguised.²⁸ Opaque ownership similarly undermines investigations by the Department of Justice by obscuring patterns of corporate-level misconduct that may otherwise trigger prosecution under the False Claims Act or criminal fraud statutes.

Existing problems include:

- The full ownership structure of the nursing home is not reported to CMS through the On-line Survey Certification and Reporting System.²⁹
- CMS presently seeks information on ownership using the Provider Enrollment, Chain, and Ownership System (PECOS). PECOS implementation, however, is still in early stages and is beset with problems.³⁰ The database is not fully populated with data on Medicare contractors. Even if PECOS were fully populated, CMS lacks the

²⁷ Sarah Slocum, *Statement on Improving Nursing Home Transparency, Enforcement, and Quality of Services*, U.S. Senate Special Committee on Aging (November 15, 2007). On-line: <http://aging.senate.gov/events/hr183ss.pdf>, accessed April 18, 2008.

²⁸ Scott A. Johnson, *Pointing the Finger at Ghosts: Potential Dangers Associated with Undercapitalization of Nursing Homes*, Testimony Before the U.S. House Committee on Ways and Means, Subcommittee on Health (November 15, 2007). On-line: <http://waysandmeans.house.gov/media/pdf/110/johnson%20testimony.pdf>, accessed April 18, 2008.

²⁹ David R. Zimmerman, *Statement*, U.S. Senate Special Committee on Aging (November 15, 2007). On-line <http://aging.senate.gov/events/hr183dz.pdf>, accessed April 18, 2008, p. 5. Harrington, op. cit.

³⁰ HHS-OIG, *Provider Enrollment, Chain and Ownership System: Early Implementation Challenges* (Washington, DC: Department of Health and Human Services, April 2007). On-line: <http://www.oig.hhs.gov/oei/reports/oei-07-05-00100.pdf>, accessed April 21, 2008.

capacity to analyze and utilize these data. Difficulties that contractors have had in accessing and using PECOS have undercut its potential effectiveness in preventing health care fraud.

- Regulation focuses on the licensed operator of the home to the exclusion of the landlord, who may affect the quality of care by exerting pressure to cut costs or by failing to make needed capital improvements.³¹
- No system exists for policing self-referrals for ancillary services within the nursing home chains.
- The requirement that the governing body of nursing homes be composed by real persons, rather than shell LLC entities, is not actively enforced.³²

Existing administrative powers under OBRA 87 that might curb these abuses are not presently exercised by CMS. Improvements are possible through enhanced Congressional oversight, more vigilant regulation, or through new legislation.

THE CASE OF HAVEN HEALTHCARE

Raymond Termini is the owner and Chief Executive Officer of Haven Eldercare, LLC and its 41 affiliated entities (Haven). Haven is one of the largest nursing home chains in the State of Connecticut (where it has 15 homes) and in the neighboring States of Massachusetts, Rhode Island, New Hampshire, and Vermont, where it has a total of 10 homes. Mr. Termini ran a construction and restaurant business before becoming an officer of Haven's predecessor in 1995. Mr. Termini began a series of questionable business dealings using the firm's assets, including in 2005, using approximately \$9 million in corporate borrowings to launch a recording studio in Nashville, called Category 5 Records. According to news reports, a Federal grand jury is currently investigating these transactions.

Mr. Termini has maintained in court filings and in the press that his use of Haven's assets to finance non-healthcare related ventures was legal and that the quality of care did not suffer. Nursing staff levels, however, in 10 of Haven's 15 homes in Connecticut fell below both the State and national averages. Moreover, although Connecticut does not generally have a reputation as one of the more "aggressive" survey States, Haven's homes in the State have been fined more than 45 times in the last 3 years for serious patient-care deficiencies. In some cases, these deficiencies have produced tragic results for residents, leading to problems such as organ failure, amputation of limbs, paralysis, and death.

Since 2004, families have filed at least eight lawsuits against Haven for negligent care. One such case is that of Oscar Aceituno, an Alzheimer's patient who wandered away from a Haven healthcare facility. Absent proper supervision, Mr. Aceituno fell, leading to injury that left him paralyzed from the waist down. Haven eventually paid only \$1 of the \$675 fine that was leveled in this case.

³¹ Zimmerman, op. cit., p. 2.

³² Nathan P. Carter, *Interview with Staff*, U.S. House Committee on Energy and Commerce, Subcommittee on Oversight and Investigations (2007).

Haven Eldercare, LLC, and its 41 affiliated entities filed for bankruptcy in November 2007. As its assets are prepared for auction on May 14, 2008, the likely buyer appears to be LifeHouse Retirement Properties, assisted by Global Advisors, LLC, a private equity firm. LifeHouse is a Michigan-based firm that presently holds several licensed and unlicensed assisted living facilities, and recently purchased a number of troubled nursing home properties in California.

WITNESSES

Panel I—Regulating Nursing Homes: Federal, State, and Local Perspectives

The following witnesses will comprise the first panel:

- **Mr. Lewis Morris** is Chief Counsel to the Inspector General for HHS. Mr. Morris will discuss lessons learned from HHS-OIG's chain-wide corporate integrity agreements and the need for increased transparency of the survey system, staffing levels, and ownership structures.
- **The Honorable Richard Blumenthal** is the Attorney General of the State of Connecticut, a position that he has held since 1991. Mr. Blumenthal will recount recent difficulties with nursing homes in Connecticut, including the case against Haven Healthcare. He will highlight the problems associated with chain ownership and the recent efforts to improve transparency in his State.
- **Mr. Luis Navas-Migueloa** is a Long Term Care Ombudsman for the City of Baltimore. Mr. Navas-Migueloa will detail the role of the ombudsman in advocating for the residents of nursing homes. He will highlight how ambiguous ownership structures undermine the ability of advocates to protect nursing home residents.
- **Mrs. Susana Aceituno** is the wife of Oscar Aceituno, who was paralyzed in an accident outside a Haven Healthcare facility in Connecticut. Mrs. Aceituno will testify to her view of the negligence by Haven in her husband's case.

Panel II—Improving Nursing Homes

The following witnesses will comprise the second panel:

- **Mr. Tom Debruin** is President of the Pennsylvania Service Employees International Union (SEIU) and sits on the International's Executive Board. Mr. Debruin began as a nursing home worker, and will offer a view of nursing homes from the workers' perspective, with an emphasis on the importance of ownership transparency and workplace culture.
- **David R. Zimmerman, Ph.D.**, is President of the Long-Term Care Institute, Inc., and Director of the Center for Health Systems Research and Analysis at the University of Wisconsin-Madison. Dr. Zimmerman has served as a chain-wide monitor pursuant to Corporate Integrity Agreements between the chains and HHS-OIG. He will testify about the need for a chain-wide perspective on quality assurance systems used in nursing homes.

- **Andrew M. Kramer, M.D.** is Professor of Medicine, Head of the Division of Health Care Policy, Director of the Center for Health Services Research, and Director of the Hartford/Jahnigen Center of Excellence at the University of Colorado. Dr. Kramer will report on weaknesses in the enforcement system and the potential usefulness of the QIS.
- **Neil L. Pruitt, Jr.**, is Chairman and Chief Executive Officer of the UHS-Pruitt Corporation and will testify on behalf of the American Health Care Association (AHCA). Mr. Pruitt will discuss voluntary efforts by the nursing home industry to improve the quality of care in the industry.
- **Mari Jane Koren, M.D., M.P.H.**, is Assistant Vice President of the Commonwealth Fund, and Chair of the “Advancing Excellence in America’s Nursing Homes” Campaign. Dr. Koren will describe the industry’s efforts to promote voluntary achievement of higher quality standards, as well as the need to have a strong enforcement system as a foundation to ensure minimum standards of quality are met.

Panel III—The Centers for Medicare and Medicaid Services

Mr. Kerry Weems is the Acting Administrator of the Centers for Medicare and Medicaid Services. Mr. Weems will discuss CMS initiatives to improve the quality of care and the effectiveness of regulation, including the Special Focus Facility program, the Quality Indicator Survey, and CMS’s *2008 Action Plan for (Further Improvement of) Nursing Home Quality*.

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If you have any questions, please contact Kristine Blackwood or Michael Heaney with the Committee on Energy and Commerce staff at ext. 6-2424.