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Congressional Requesters

Subject: *Nursing Homes: Opportunities Exist to Facilitate the Use of the Temporary Management Sanction*

This Report is Temporarily Restricted  
Pending Official Public Release.

The nation's 1.4 million nursing home residents are a highly vulnerable population of elderly and disabled individuals for whom remaining at home is no longer feasible. The federal government plays a key role in ensuring that nursing home residents receive appropriate care by setting quality requirements that nursing homes must meet to participate in the Medicare and Medicaid programs and by contracting with states to conduct routine inspections—called standard surveys—and complaint investigations.<sup>1</sup> To encourage compliance with quality requirements, Congress has authorized certain enforcement actions, known as sanctions, such as civil money penalties or termination from participating in the Medicare and Medicaid programs. The Centers for Medicare & Medicaid Services (CMS) is responsible for imposing federal sanctions, typically on the basis of states' recommendations.<sup>2</sup> One sanction—temporarily replacing a home's management—has been used infrequently. According to CMS guidance, temporary management may be used instead of termination in cases where nursing homes place residents at risk of death or serious injury—referred to as immediate jeopardy—or place residents at widespread risk of actual harm. CMS requires that a nursing home remove any immediate jeopardy within a short time frame of 23 calendar days after the survey or complaint investigation in which it was cited, with or without the assistance of temporary management. Otherwise, CMS will terminate the home from Medicare and Medicaid. In some cases, the nursing home's owner may choose to sell the home to a new owner while the home is still under temporary management.

You were interested in information on why the temporary management sanction has been used infrequently to address nursing home quality problems and asked us to study this issue. Specifically, we focused on (1) CMS and states' experience with the use of federal temporary management and its effectiveness in achieving compliance in the short and longer term; and (2) obstacles to the use of federal temporary management and how such obstacles could be addressed. You also asked us to examine whether changes in ownership occurred when nursing homes were under federal temporary management and to identify obstacles to such ownership changes. We provide this information in enclosure I.

<sup>1</sup>Medicare is the federal health care program for elderly and disabled people. Medicaid is the joint federal-state health care financing program for certain categories of low-income individuals. Medicare covers up to 100 days of skilled nursing home care following a hospital stay; Medicaid also pays for long-term care services, including nursing home care.

<sup>2</sup>CMS is an agency within the Department of Health and Human Services.

To examine CMS and states' experience with the use of federal temporary management and its effectiveness in achieving compliance in the short and longer term, we identified the states where the sanction was used from fiscal years 2003 through 2008 by analyzing data from CMS's Providing Data Quickly (PDQ) reporting system.<sup>3</sup> We assessed the short-term effectiveness of temporary management by the sanction's ability to achieve its intended objective, which primarily was to return the home to compliance with federal quality requirements. We assessed the longer-term effectiveness of temporary management by the ability of a home to maintain substantial compliance after the conclusion of temporary management. From fiscal years 2003 through 2008, the federal temporary management sanction was used in 14 nursing homes across 10 states; these 10 states were located in 7 of 10 CMS regions (see enc. II).<sup>4</sup> We interviewed officials from 1 of the 10 state survey agencies and its corresponding CMS regional office and then sent a set of similar questions to the remaining state survey agencies and regional offices.<sup>5</sup> Officials from all 10 states confirmed the use of the sanction and together with the seven CMS regional offices provided information for our analysis on: (1) common characteristics of instances in which the sanction was used; (2) the sanction's ability to correct quality-of-care problems; and (3) instances of immediate jeopardy when federal temporary management was not used. In addition, we analyzed data from CMS's On-line Survey, Certification, and Reporting system (OSCAR) on the compliance history of the 14 homes subject to federal temporary management from fiscal years 2003 through 2008.<sup>6</sup> To ensure the reliability of the OSCAR data we analyzed, we interviewed CMS officials, reviewed CMS documentation, conducted electronic testing to identify obvious errors, and traced a selection of records to another CMS reporting system. Based on these activities, we determined the data we analyzed were sufficiently reliable for our purposes. In addition, we used CMS data from PDQ and the Nursing Home Compare Web site to identify characteristics of the 14 homes, such as the number of certified beds and ownership type. To ensure the reliability of these data, we interviewed CMS regional officials, reviewed CMS documentation, and confirmed the accuracy of some data elements with state or CMS regional officials. Based on these activities, we determined the data were sufficiently reliable for our purposes.

To examine obstacles to the use of federal temporary management and how they could be addressed, we received additional information from 9 of the 10 states and seven CMS regional offices where the sanction was used from fiscal years 2003 through 2008.<sup>7</sup> We also sent a standardized set of questions to the remaining 41 states. Officials from 37 of the 41 states confirmed that the sanction had not been used from fiscal years 2003 through 2008 and

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<sup>3</sup>PDQ is an online reporting system that provides a variety of reports using CMS survey data. From fiscal year 1995—the first year the federal temporary management sanction was available—through fiscal year 2002, the sanction was used in 11 homes. Because of the likelihood that information on sanctions used so long ago would be limited, we focused on those instances in which the sanction was used from fiscal years 2003 through 2008.

<sup>4</sup>The 10 states that used federal temporary management were California, Colorado, Connecticut, Maine, Michigan, New Jersey, South Dakota, Tennessee, Texas, and Vermont. These states are located in the Atlanta, Boston, Chicago, Dallas, Denver, New York, and San Francisco CMS regions.

<sup>5</sup>Throughout this report, we refer to state survey agencies, including the District of Columbia agency, as "states."

<sup>6</sup>One of the 14 homes began participating in Medicare and Medicaid the same year that temporary management was used, and therefore compliance history data prior to temporary management were not available for this home.

<sup>7</sup>One state provided information about its experience using federal temporary management, but did not provide information about obstacles to the use of the sanction and how they could be addressed.

responded to our questions.<sup>8</sup> Overall, we received and analyzed responses from 46 states and seven CMS regional offices on (1) obstacles to the effective use of the sanction; (2) existence and maintenance of state temporary manager lists; (3) use of state alternatives to federal temporary management; (4) obstacles to bringing about a change in ownership in cases where federal temporary management was used; and (5) suggestions for improving the federal temporary management sanction. Finally, GAO discussed state alternatives to temporary management, funding options for temporary management, and suggestions for improving the sanction at a membership meeting of the Association of Health Facility Survey Agencies (AHFSA), the organization that represents state survey agencies.

We conducted this performance audit from February 2009 through November 2009 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

### **Results in Brief**

Based on responses from officials in the 10 states and seven CMS regional offices that used the federal temporary management sanction from fiscal years 2003 through 2008, the sanction was used with success in the short term in homes where there was some combination of immediate jeopardy, a history of noncompliance with CMS quality requirements, or the failure of other sanctions to bring about compliance. In 11 of the 14 homes, officials used the sanction with the objective of returning the home to compliance with federal quality requirements, and in 10 of those homes temporary management was successful in the short term at doing so. However, some homes continued to have compliance problems in the longer term, that is, since the conclusion of temporary management. For example, while 9 of these 10 homes remained open as of August 2009, CMS data showed that 4 of them were cited for immediate jeopardy after temporary management.

Officials from 46 states and seven CMS regional offices identified several obstacles to using federal temporary management, including time constraints, a lack of qualified temporary managers, and inadequate funding to pay for a temporary manager. Specifically, officials from 24 states and five CMS regional offices characterized the 23 days as a short time frame in which to hire a temporary manager and remove immediate jeopardy before automatic termination from participation in Medicare and Medicaid, therefore making it difficult to use the sanction. Additionally, officials from 25 of the 46 states told us they did not maintain a list of potential temporary managers, which could impede their ability to identify qualified candidates on a timely basis. State and CMS regional officials also identified ways for CMS to address some of the obstacles to using the sanction, such as developing lists of qualified temporary managers and providing additional information that addresses best practices and when and how to use the sanction. In addition, several officials suggested the need for an approach to help ensure the longer-term success of temporary management.

To improve the usefulness of the federal temporary management sanction, we are recommending that the Administrator of CMS take the following three actions: (1) create and maintain lists of qualified temporary managers; (2) develop information that identifies best practices such as when and how to use the sanction; and (3) develop guidance for states to

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<sup>8</sup>Delaware, the District of Columbia, Nevada, and New York did not respond.

help ensure the longer-term compliance of homes that have undergone temporary management. We provided a draft of this report to the Department of Health and Human Services and AHFSA for comment. In response, CMS said that our study added value to the important public policy discussions regarding the use of temporary management, an important tool that states can recommend and CMS can impose in situations of immediate jeopardy. CMS said that it endorsed the spirit of our recommendations but did not fully agree with all of them. Specifically, CMS agreed to develop additional information that identifies best practices for states and said that it would explore alternatives to the development of state guidance intended to help ensure the longer-term compliance of homes. However, the agency indicated that it did not plan to create lists of temporary managers. AHFSA agreed with the need for CMS to provide clearer information on the temporary manager process, but did not say whether it agreed with our other two recommendations. While we recognize that the development and maintenance of lists of temporary managers will require time and resources on the part of states and CMS, we maintain that the full potential of what CMS characterizes as an important tool will not be fully realized without such lists.

## **Background**

Titles XVIII and XIX of the Social Security Act established minimum federal quality requirements that all nursing homes must meet to participate in the Medicare and Medicaid programs, respectively.<sup>9</sup> With the Omnibus Budget Reconciliation Act of 1987 (OBRA 87), Congress focused the requirements on the quality of care actually provided by a home.<sup>10</sup>

### Ensuring Compliance with Federal Quality Requirements

CMS contracts with states to assess whether nursing homes meet federal quality requirements through standard surveys and complaint investigations.<sup>11</sup> A standard survey involves a comprehensive assessment of quality requirements, while complaint investigations generally focus on a specific allegation regarding resident care or safety. States classify deficiencies identified during either standard surveys or complaint investigations in 1 of 12 categories, labeled A through L, according to their scope (i.e., the number of residents potentially or actually affected) and severity (i.e., the degree of relative harm involved). Homes with deficiencies at the A through C levels are considered to be in substantial compliance with federal quality requirements, while those with D-level or higher deficiencies are considered noncompliant (see table 1). Deficiencies at the J level or higher constitute immediate jeopardy, a situation in which the home's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.

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<sup>9</sup>By law, obtaining a state license to operate—by meeting specific state requirements—is one prerequisite for a home to participate in Medicare and Medicaid. 42 U.S.C. §§ 1395i-3(d)(2)(A), 1396r(d)(2)(A).

<sup>10</sup>Pub. L. No. 100-203, §§ 4201, 4211, 101 Stat. 1330, 1330-160, 1330-182 (codified in pertinent part at 42 U.S.C. § 1395i-3 and 42 U.S.C. § 1396r).

<sup>11</sup>Every nursing home receiving Medicare or Medicaid payment must undergo a standard survey not less than once every 15 months, and the statewide average interval for these surveys must not exceed 12 months.

**Table 1: Scope and Severity of Deficiencies Identified during Standard Surveys and Complaint Investigations**

Severity	Scope		
	Isolated	Pattern	Widespread
Immediate jeopardy <sup>a</sup>	J	K	L
Actual harm	G	H	I
Potential for more than minimal harm	D	E	F
Potential for minimal harm <sup>b</sup>	A	B	C

Source: CMS.

<sup>a</sup>Actual or potential for death/serious injury.

<sup>b</sup>Nursing home is considered to be in “substantial compliance.”

### Federal and State Enforcement

Nursing homes that fail to meet federal quality requirements may be subject to statutory federal enforcement actions known as sanctions. CMS and the states share responsibility for federal enforcement actions. States are responsible for enforcing federal requirements in homes with Medicaid-only certification and may also impose enforcement actions under state licensure authority.<sup>12</sup>

In general, federal sanctions are (1) initially proposed by the state based on a cited deficiency, (2) reviewed and imposed by CMS regional offices, and (3) implemented—that is, put into effect—by the same regional office, usually after a required notice period.<sup>13</sup> Sanctions are generally reserved for serious deficiencies—those at the G through L levels—and the severity of sanctions typically increases with the severity of the deficiency. Sanctions include fines known as civil money penalties (CMP), denial of payment for new Medicare or Medicaid admissions (DPNA), directed plan of correction, state monitoring, temporary management, and termination from the Medicare or Medicaid program, or both.<sup>14</sup>

When a nursing home is cited with one or more deficiencies that constitute immediate jeopardy to resident health or safety, the law requires immediate action to remove the deficiencies through the use of federal temporary management or termination from Medicare and Medicaid.<sup>15</sup> In addition, other sanctions may be imposed. CMS interprets the law’s requirement for “immediate” action to remove the jeopardy and correct the deficiencies by establishing the time frame of 23 calendar days from the date of the standard survey or

<sup>12</sup>As of December 31, 2008, almost 91 percent of nursing homes were certified to participate in Medicare and Medicaid, about 5 percent were only certified to participate in Medicare, and about 4 percent were only certified to participate in Medicaid.

<sup>13</sup>CMS can also impose federal sanctions that the state has not recommended. Throughout this report, we refer to the imposition and implementation of a sanction as “use” of the sanction.

<sup>14</sup>Overall, CMPs and DPNAs accounted for about 76 percent of federal sanctions imposed from fiscal years 2003 through 2008. Terminating a nursing home eliminates its eligibility to receive Medicare and Medicaid payments and can result in a home’s closure; termination accounted for less than 1 percent of federal sanctions imposed from fiscal years 2003 through 2008.

<sup>15</sup>42 U.S.C. §§ 1395i-3(h), 1396r(h); see 42 C.F.R. § 488.408 (2008). In the absence of immediate jeopardy, temporary management, another sanction, or termination may also be used.

complaint investigation that cited the deficiency.<sup>16</sup> In contrast, a nursing home has 6 months to return to substantial compliance for non-immediate-jeopardy level deficiencies.

In lieu of a federal sanction, a state may (1) use an acceptable alternative that it has demonstrated to CMS is as effective in deterring noncompliance and correcting deficiencies and that CMS has approved, or (2) use its own sanctions under the state's licensure authority.<sup>17</sup> Examples of approved state alternative sanctions to federal temporary management or similar sanctions that states may use under their licensure authority include state temporary management, receivership, and trusteeship; the latter two sanctions are similar to temporary management but require court involvement.<sup>18</sup>

### Federal Temporary Management

CMS regional offices use temporary management to achieve one of two objectives: (1) to correct deficiencies and return the home to substantial compliance with federal quality requirements, or (2) to oversee orderly closure of a nursing home and relocation of residents.<sup>19</sup> The nursing home must voluntarily agree to relinquish control to the temporary manager and to pay his/her salary as well as pay for improvements to the home that the temporary manager deems necessary.<sup>20</sup> However, if the home refuses to relinquish control to the temporary manager, the home will be terminated from Medicare and Medicaid within 23 calendar days if the immediate jeopardy is not removed. A temporary manager has full authority to hire, terminate, or reassign staff; spend nursing home funds; alter nursing home procedures; and otherwise manage a home to achieve the objective.<sup>21</sup> The CMS regional office selects the temporary manager based on state recommendations.<sup>22</sup> CMS guidance recommends that states maintain a list of eligible temporary managers who meet certain criteria set by CMS—such as not having worked for the home in the past 2 years—and whose past performance, work experience, and education indicate that they are qualified to serve as temporary managers.<sup>23</sup> The state can request the temporary manager to periodically report on the actions taken to achieve compliance. Temporary management generally continues until a home is terminated from Medicare and Medicaid or achieves and demonstrates to the CMS

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<sup>16</sup>See 42 U.S.C. §§ 1395i-3(h)(2)(A), 1396r(h)(3); 42 C.F.R. § 488.410 (2008).

<sup>17</sup>See 42 U.S.C. § 1396r(h)(2)(B)(ii); 42 C.F.R. § 488.406 (c). Homes must meet certain state-determined criteria for the state to impose a state alternative sanction.

<sup>18</sup>Throughout this report, we refer to CMS-approved alternative sanctions or state licensure sanctions as state alternative sanctions.

<sup>19</sup>See 42 U.S.C. §§ 1395i-3(h)(2)(B)(iii), 1396r(h)(3)(C)(iii). Through the *State Operations Manual*, CMS provides guidance based on the statutes to regional offices and states on the use of the federal temporary management sanction.

<sup>20</sup>The temporary manager's salary must be at least equivalent to the prevailing annual salary of nursing home administrators in the home's area including the cost of benefits, prorated for the amount of time the temporary manager spends in the home.

<sup>21</sup>When CMS appoints a state-recommended temporary manager and a home agrees, the temporary manager and the home negotiate the terms of temporary management—such as the temporary manager's authorities, duties, and compensation.

<sup>22</sup>In the case of a Medicaid-only nursing home, the state Medicaid agency selects the temporary manager.

<sup>23</sup>CMS decided not to require that temporary managers be licensed nursing home administrators in order to expand the number of eligible candidates.

regional office and the state the capability of maintaining substantial compliance—no deficiencies higher than C level.

### CMS Efforts to Identify Nursing Homes with Poor Compliance Histories

CMS makes information on the compliance history of nursing homes available to the public through its Nursing Home Compare Web site. For every nursing home that participates in Medicare and Medicaid, the Web site provides information on deficiencies cited during standard surveys and any intervening complaint investigations. It also identifies those homes with poor compliance histories that have been designated Special Focus Facilities (SFF). Through the SFF Program, CMS monitors a limited number of such nursing homes; states are required to survey SFFs twice as frequently as other nursing homes.<sup>24</sup>

In addition, the Nursing Home Compare Web site provides a rating for each nursing home from one (much below average) to five (much above average) stars, known as the Five-Star Quality Rating System.<sup>25</sup> CMS implemented this new rating system in December 2008. A nursing home's overall quality rating is based on individual ratings for three separate components: (1) compliance history; (2) staffing levels; and (3) quality-of-care measures.<sup>26</sup> A home's compliance history—results from the last 3 years of a home's standard surveys and complaint investigations—is the most important component in determining the overall quality rating.<sup>27</sup>

### **Federal Temporary Management Used for Homes with Histories of Noncompliance, and These Homes Generally Corrected Deficiencies in the Short Term, but Some Had Longer-Term Compliance Problems**

Based on responses from officials in the 10 states and seven CMS regional offices that used federal temporary management from fiscal years 2003 through 2008, the sanction was primarily used for homes with some combination of immediate jeopardy level deficiencies, histories of noncompliance, or continuing noncompliance despite the use of other sanctions. Most homes under temporary management corrected deficiencies in the short term, but some homes continued to have compliance problems in the longer term.

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<sup>24</sup>The SFF Program focuses on 136 nursing homes in every state except Alaska; the number of SFFs per state ranges from 1 to 6 based on the number of homes in the state. See GAO, *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.: Aug. 28, 2009).

<sup>25</sup>A two-star rating means a home ranks "below average;" a three-star rating means "about average;" and a four-star rating means "above average."

<sup>26</sup>The second component of the five-star quality rating—staffing levels—is based on nursing homes' reported total nursing hours per resident day and registered nurse hours per resident day. The third component is based on nursing home performance on 10 quality-of-care measures, such as the percentage of high-risk residents who have pressure sores.

<sup>27</sup>In calculating the compliance history rating, the most recent survey findings are weighted more than the prior two surveys. The overall quality rating is capped in two circumstances. First, if a nursing home's compliance history is one star, then the overall quality rating cannot exceed two stars. Second, nursing homes currently in the SFF program have their overall quality rating capped at three stars even if they have high ratings in individual components.

Federal Temporary Management Used for Homes with Immediate Jeopardy, Histories of Noncompliance, or When Other Sanctions Were Ineffective

State and CMS regional officials told us that for 13 of the 14 homes where the federal temporary management sanction was used from fiscal years 2003 through 2008 a combination of several factors such as immediate jeopardy level deficiencies, repeated noncompliance with federal quality requirements, or the failure of other sanctions to bring about compliance led them to use the sanction.<sup>28</sup> In all but 3 of the 14 homes, immediate jeopardy as well as other deficiencies were identified on the survey or surveys that led officials to use the sanction.<sup>29</sup> For example, a home in South Dakota had a history of noncompliance resulting in multiple federal sanctions, including a DPNA, which officials told us had been ineffective in deterring noncompliance. On one survey, the home was cited with two immediate jeopardy level deficiencies and placed under temporary management.<sup>30</sup> Enclosure III summarizes the compliance history and the objectives and outcomes of the 14 homes in which federal temporary management was used during the period we studied.

CMS compliance data on standard surveys and complaint investigations confirm that most of the 14 homes had histories of noncompliance prior to the imposition of temporary management.<sup>31</sup> In analyzing the compliance history of the 14 homes, we found that they averaged 37 D–L level deficiencies in the year immediately prior to temporary management, far more than the nationwide average of about 8 D–L level deficiencies in fiscal year 2008.<sup>32</sup> Furthermore, 12 of the 13 homes where survey data were available had between 1 and 20 deficiencies at the actual harm level (G–I) over the 3 years prior to the survey that resulted in temporary management. Four of those homes also had at least 1 immediate jeopardy level deficiency (J–L) in that same time period. Although the 13th home did not have a history of actual harm or immediate jeopardy level deficiencies, the survey that led to temporary management identified 9 actual harm and 44 immediate jeopardy deficiencies (see enc. III). Four of the 14 homes were in CMS’s SFF program at the time they were placed under federal temporary management, indicating that CMS had previously identified the homes as having histories of noncompliance.

In addition to instances of immediate jeopardy and a poor compliance history, state and CMS regional officials gave several reasons for using federal temporary management to bring the homes into compliance.<sup>33</sup> Officials in four states told us they recommended that CMS use temporary management when they considered the home’s current administration to be

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<sup>28</sup>For the remaining home, officials told us that they used temporary management solely because of multiple immediate jeopardy deficiencies. CMS typically uses other federal sanctions before turning to temporary management.

<sup>29</sup>The three homes where immediate jeopardy was not identified in the survey that led to temporary management were not subject to the 23-day termination time frame.

<sup>30</sup>We previously reported that many homes frequently cycle in and out of compliance; see GAO, *Nursing Homes: Efforts to Strengthen Federal Enforcement Have Not Deterred Some Homes from Repeatedly Harming Residents*, GAO-07-241 (Washington, D.C.: Mar. 26, 2007).

<sup>31</sup>The 14 nursing homes in which the sanction was used were located throughout the United States, mostly for-profit, and generally not part of a nursing home chain (see enc. II).

<sup>32</sup>The average includes two homes with a high number of D–L deficiencies in comparison to the other homes. Excluding these two homes results in an average of 30 D–L deficiencies during the year prior to temporary management.

<sup>33</sup>In 6 of the 14 homes, CMS or state officials told us they used other sanctions, such as a CMP, in addition to federal temporary management.



incapable of improving conditions. For example, one home had significant staff turnover, including at the management level, which led the state and CMS officials to question the home's ability to correct deficiencies and maintain compliance without outside help. In another four homes, state officials told us they recommended temporary management in part because termination would have resulted in relocating residents a great distance due to the limited available nursing home space in the area or because specialized services were offered at only a limited number of homes in the state.

State officials told us that they did not recommend temporary management in instances of immediate jeopardy when they determined that the nursing home could correct the immediate jeopardy on its own.<sup>34</sup> For example, in many cases a home's management demonstrated that it could resolve the deficiencies and did so quickly. In some cases, states recommended the use of other federal sanctions such as CMPs to encourage the home to correct the deficiencies, or otherwise monitored the home.<sup>35</sup> Thus, two states recommended a home for the SFF program and others used directed plans of correction requiring homes to hire independent consultants to address conditions that resulted in the citation of deficiencies.<sup>36</sup>

#### While Most Homes under Temporary Management Corrected Deficiencies in the Short Term, Some Were Unable to Maintain Compliance in the Longer Term

According to CMS regional office and state officials, federal temporary management was successful in achieving its intended objective in the short term in 13 of the 14 homes.<sup>37</sup> First, in 11 of the 14 homes, federal temporary management was used with the objective of correcting deficiencies that caused the home to be noncompliant with federal quality requirements; in 10 of these 11 homes, temporary management was successful in achieving this objective. The home that failed to return to substantial compliance was terminated from Medicare and Medicaid, and closed. Second, in 2 of the 14 homes, the sanction was used to oversee the orderly closure of and relocation of residents from homes that the state and CMS had determined could not oversee orderly closure on their own; both homes were closed successfully. Finally, in the remaining home, the objective changed from bringing the home into substantial compliance to overseeing orderly closure of the home when the temporary manager determined that the home was not financially viable; the sanction was successful in achieving the latter objective (see enc. III).<sup>38</sup>

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<sup>34</sup>States cited about 3,900 nursing homes with immediate jeopardy level deficiencies from fiscal years 2003 through 2008; temporary management was used 14 times and termination 163 times in those years.

<sup>35</sup>States also have the option of using a state alternative to temporary management or other state sanctions if the home has not met state licensing requirements.

<sup>36</sup>According to PDQ, directed plans of correction were used 1,429 times in fiscal years 2003 through 2008.

<sup>37</sup>In most homes for which information was available, the temporary manager was an individual employed by a management company. In one case, a company hired as the temporary manager installed a team that included a licensed nursing home administrator, a medical director, and a director of nursing, among others, to manage the home.

<sup>38</sup>The duration of temporary management ranged from less than a month to about 16 months and averaged about 6 months, with generally shorter durations for homes where temporary management oversaw closure of the home. Generally, temporary management ended when either the home was determined to be in substantial compliance or the home closed.

In addition to assisting homes with returning to substantial compliance, state officials told us that the temporary managers also brought about changes to improve the quality of care in the nursing homes and to ensure the homes were capable of maintaining substantial compliance. For example, at four homes the temporary manager was required to conduct an initial assessment of the home and develop initiatives to maintain compliance with federal quality requirements.<sup>39</sup> Other examples of actions taken by the temporary managers included instituting training for nursing home staff, filling staff positions, implementing resident care plans, updating the homes' policies and procedures, purchasing and implementing billing software updates, and identifying needed building improvements. Specifically, the temporary manager in one home identified that the cooling system needed to be replaced to ensure resident safety. Some CMS regional office and state officials told us that the temporary managers periodically reported on their activities and progress throughout the duration of temporary management.

Based on responses from officials in the 10 states and seven CMS regional offices that used federal temporary management from fiscal years 2003 through 2008 to questions about the use of the sanction, we identified several factors that influenced the successful use of the sanction.<sup>40</sup>

- Coordination and communication. In part because the sanction's use required a considerable investment of time and resources, coordination and frequent communication between the temporary manager, state, and CMS regional office were important to the sanction's success.
- Cooperation of nursing home owner. Lack of cooperation from the owner in providing the temporary manager complete control of expenditures, personnel, and policies at the home impeded the success of the temporary manager. At the one home that temporary management was unable to return to substantial compliance, officials told us that the owner did not grant the temporary manager enough control and was not committed to improving the quality of care. In this case, the home was terminated from Medicare and Medicaid and closed.
- Available funding for temporary management. The home's ability to pay for temporary management or the availability of other funding sources was important to the successful use of the sanction. In all but two homes, the home funded temporary management; in one home, funding was provided by state CMP funds and, in the other, the home's creditor provided the home with funding to pay for the temporary manager. The temporary manager's monthly compensation ranged from less than \$15,000 to \$60,000 for the six homes where officials were able to provide us with cost information. In addition, officials noted that changes implemented by the temporary manager, such as building improvements, advanced billing software, or hiring of staff, were costly for the home. For example, in one home, the objective of temporary management changed to overseeing closure of the home after the temporary manager determined that the home did not have enough funding to pay for changes required to return the home to compliance.

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<sup>39</sup>CMS regional office or state officials were only able to provide the agreement between the home and the temporary manager for these four homes.

<sup>40</sup>Officials from three states did not provide us with information regarding factors that influenced the ability of temporary management to achieve its objective in part because of the amount of time that had passed since the sanction was used.

Although most homes corrected deficiencies in the short term, some homes continued to have compliance problems in the longer term. Nine of the 10 homes that returned to substantial compliance while under temporary management were still participating in the Medicare and Medicaid programs as of August 2009.<sup>41</sup> However, state and CMS regional officials told us that 5 homes continued to have problems after the conclusion of temporary management. For example, 1 of the 5 homes was selected to participate in the SFF Program, and for another home the state used its own temporary management sanction within 2 years after the conclusion of federal temporary management.

Our analysis of CMS deficiency data found that four of the nine homes still participating in Medicare and Medicaid as of August 2009 had been cited with at least one immediate jeopardy level (J–L) deficiency since temporary management was used.<sup>42</sup> In addition, four of the nine homes where temporary management concluded at least 2 years prior to August 2009 had one or two stars (much below or below average) in CMS’s Five-Star Quality Rating System.<sup>43</sup> Three homes had either three or four stars (about average or above average) (see enc. III).<sup>44</sup>

### **Officials Identified Obstacles to the Sanction’s Use and Suggested Lists of Qualified Temporary Managers and Additional Information to Address Them**

Officials from the 46 states and seven CMS regional offices that provided us with information identified three key obstacles to the use of federal temporary management and suggested ways to address some of the obstacles.

#### Officials Identified Three Key Obstacles to the Sanction—Time Constraints, Lack of Qualified Temporary Managers, and Inadequate Funding

The three obstacles most frequently identified by state and CMS regional officials to using federal temporary management were time constraints, lack of qualified temporary managers, and inadequate funding (see table 2).

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<sup>41</sup>The 10th home closed less than 2 years after the conclusion of temporary management.

<sup>42</sup>This includes three of the five homes that state and CMS regional officials identified as having continued problems after the conclusion of temporary management.

<sup>43</sup>For one of the homes with a one-star rating, the results from complaint investigations that occurred while temporary management was in place were included in CMS’s calculation of the rating.

<sup>44</sup>We did not report the rating for two of the nine homes because the results from at least two surveys that occurred prior to temporary management or while temporary management was in place were included in CMS’s calculations of these ratings.

**Table 2: Most Frequently Identified Obstacles to Using the Federal Temporary Management Sanction**

<b>Obstacle</b>	<b>Number of states that identified this obstacle</b>	<b>Number of CMS regional offices that identified this obstacle</b>
Not enough time to find a temporary manager and remove immediate jeopardy within 23 days	24	5
Lack of qualified or experienced temporary managers	23	4
Home lacks adequate funding to pay for temporary manager	20	5
Use state alternative sanction	15	1
Prefer to allow home to come into compliance on its own	12	0
Uncertainty about when to use the sanction or what to expect from temporary manager	12	0

Source: GAO.

Note: Data are responses to GAO questions from officials from 46 states and seven CMS regional offices.

- **Time constraints:** Within 23 days (1) officials must identify and place a temporary manager in a home and (2) the temporary manager must remove the immediate jeopardy or the home will be terminated from participation in Medicare and Medicaid. Officials from 24 states and five CMS regional offices indicated that this time frame is short and therefore makes it difficult to pursue temporary management. For example, officials from a regional office told us of a case where state officials recommended using federal temporary management, but it was already day 19 on the termination timeline and the state did not have a list of potential temporary managers, so the CMS officials determined the sanction was not feasible.
- **Lack of qualified temporary managers:** Officials from 23 states and four CMS regional offices identified a lack of qualified or experienced temporary managers as an obstacle to the use of the sanction. Although CMS guidance recommends that states maintain a list of eligible temporary managers, officials from 25 states told us they do not, which could impede their ability to identify qualified temporary managers when use of the sanction may be appropriate. Officials from 21 states reported that they do maintain such a list, but only 11 had updated their list within the last 2 years. A few state officials also indicated that qualified candidates may not be willing to accept a temporary manager position because, for example, they are otherwise employed or do not want the liability associated with managing a poorly performing home.
- **Inadequate funding:** Officials from 20 states and five CMS regional offices reported that homes' lack of adequate funding to pay for temporary management can be an obstacle to using the sanction. For one of the homes where federal temporary management was used from fiscal years 2003 through 2008, the temporary manager was paid from CMP funds because the home did not have sufficient funding; however, officials from this state noted there are not enough CMP funds to pay for more frequent use of temporary management.<sup>45</sup>

<sup>45</sup>By law, states receive funds from CMPs collected from Medicaid-only nursing homes, as well as the Medicaid portion of homes that participate in both Medicare and Medicaid. These funds must be applied to the protection of the health or property of residents of homes that the state or CMS finds deficient, such as payment for the costs of relocation of residents to other homes or operation of a home pending correction of deficiencies or closure. See 42 U.S.C § 1396r(h)(2)(A)(ii). There is no requirement in the Social Security Act that the Medicare portion of CMP funds be used for a specific purpose; the funds are deposited as miscellaneous receipts into the U.S. Treasury.

State and CMS regional officials also identified other obstacles to the use of federal temporary management such as employing other sanctions to achieve compliance instead of federal temporary management; having previously unsuccessful experiences with temporary management; and investing significant time and resources to use the sanction.

As shown in table 2, officials from 15 states indicated that they used their state alternative sanctions—state authority to use temporary management, receivership, or trusteeship. Overall, however, state officials' responses indicated that the substitution of a state alternative for the federal sanction is limited. Specifically, officials from 17 of 32 states with state alternative sanctions to federal temporary management did not use their alternatives from fiscal years 2003 through 2008, and officials from 13 states reported not having such alternative sanctions.<sup>46</sup> Officials from only 2 states—California and Texas—reported using the alternatives an average of more than three times a year during the 6-year period.<sup>47</sup>

Officials from five states indicated that both the federal temporary management sanction and their state alternative sanctions were used from fiscal years 2003 through 2008, suggesting that the federal sanction might be appropriate in certain situations while the state alternatives might work better in others. For example, a Texas official told us that when using the alternative sanction the state can (1) act more quickly because it does not have to coordinate with the nursing home, and (2) use state funds to pay for the sanction. In contrast to the federal sanction, a nursing home may not refuse the Texas alternative sanction. In the one case in which Texas used the federal temporary management sanction during the period we studied, officials reported that they were unable to use the preferred state alternative because the home did not meet criteria required to obtain a court order to appoint a trustee to oversee the home.

#### Officials Identified Lists of Qualified Temporary Managers and Additional Information on the Sanction's Use as Ways to Address Obstacles

State and CMS regional officials identified ways to address some obstacles and facilitate the use of the federal temporary management sanction. First, to address the lack of qualified or experienced candidates to serve as temporary managers, officials from 9 states and three CMS regional offices suggested that CMS or states could develop a list of candidates that could be available when temporary management was an appropriate sanction. Second, officials from 12 states reported being uncertain about when to use the sanction or what to expect from a temporary manager, or both. To address this uncertainty, officials from 7 states and two CMS regional offices suggested that CMS could provide more specific information regarding when or how to use it effectively. Officials from 1 state specifically noted that before considering the use of the sanction in their state they would find it helpful to have information from CMS on best practices so that they would know how the sanction has worked in other instances.

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<sup>46</sup>An official from one state did not indicate whether the state had an alternative sanction to federal temporary management. According to the state's administrative code, the state had the authority to impose temporary management in nursing homes that participate in Medicaid; however, we do not know if the state used this sanction from fiscal years 2003 through 2008.

<sup>47</sup>In addition, officials from Connecticut reported using the state alternative sanction several times a year.

In addition, officials from 4 states and two CMS regional offices suggested that alternative or additional funding sources for temporary management could facilitate the sanction's use. Officials from 2 states and one CMS regional office also suggested that CMS could establish an approach to help ensure the longer-term compliance of homes where temporary management was used, such as allowing the temporary manager to continue for some time after a home returns to substantial compliance or implementing an automatic reactivation of temporary management if the home does not maintain substantial compliance over the 2 years following the sanction. Although officials from 24 states and five CMS regional offices identified the short 23-day time frame to remove immediate jeopardy as an obstacle to the use of federal temporary management, officials from only 1 state and one CMS regional office recommended extending the time frame, which could lengthen the period of time residents are exposed to the risk of death or serious injury.

## **Conclusions**

Infrequent use of federal temporary management appears to be the result of (1) the availability of other sanctions, such as CMPs, that states and regional offices deem more appropriate in certain situations, and (2) state and regional office determinations that many homes can address immediate jeopardy deficiencies without the assistance of a temporary manager. Nonetheless, officials identified several obstacles that may prevent the use of temporary management when appropriate or factors that influence the sanction's success when it is used. Although officials identified the short 23-day termination time frame as an obstacle to using federal temporary management, extending the time frame could result in nursing homes taking more time to abate immediate jeopardy deficiencies, thereby placing nursing home residents at risk for longer periods.

Other obstacles that officials identified may be more easily addressed, such as a lack of qualified temporary managers and insufficient information illustrating best practices, including when or how to use temporary management. Though addressing these obstacles could increase use of the sanction when appropriate or its short-term effectiveness, the longer-term effectiveness of the sanction is difficult to assess because 5 of the 9 homes that underwent temporary management and remained open have not been able to consistently maintain compliance. Such longer-term compliance problems suggest the need for enhanced oversight.

## **Recommendations for Executive Action**

To address obstacles to the use of the federal temporary management sanction, we recommend that the Administrator of CMS work with states to implement the following two actions:

- Create and maintain a list or lists of qualified temporary managers on either a regional or national basis.
- Develop additional information that identifies best practices for states and regional offices, including when and how to use the sanction, the essential qualifications for temporary managers, and alternative funding sources available for temporary management, such as CMP funds.

To help ensure the longer-term compliance of nursing homes that have successfully returned to substantial compliance under temporary management, we recommend that the Administrator of CMS develop guidance for states to enhance their oversight of such homes, such as implementing reactivation of temporary management if the home does not maintain substantial compliance over the 2 years following the conclusion of the sanction.

### **Agency and Other External Comments and Our Evaluation**

We provided a draft of this report to the Department of Health and Human Services and AHFSA for comment.<sup>48</sup> In its written comments, CMS said that our study added value to the important public policy discussions regarding the use of temporary management, an important tool that states can recommend and CMS can impose in situations of immediate jeopardy. While CMS endorsed the spirit of our recommendations, the agency indicated that it did not plan to implement all of them. Specifically, CMS agreed with one recommendation, indicated that it would explore alternatives to a second recommendation, and noted that it did not plan to implement the third recommendation. CMS's comments are reproduced in enclosure IV. We also received written comments from AHFSA, which agreed with one recommendation but did not comment on whether it agreed with the other two. CMS and AHFSA also provided additional information, which we summarize below.

CMS agreed with our recommendation to develop additional information that identifies best practices for states and regional offices to assist in their use of temporary management. AHFSA agreed that there was a need for CMS to provide clearer information to states regarding the process involved with using temporary management; additionally, AHFSA commented that one state suggested CMS should develop performance measures or benchmarks for nursing homes that, if not met, would require the use of a temporary manager.

CMS indicated that it intended to broaden the scope of our recommendation to develop guidance for states to enhance the agency's longer-term oversight of nursing homes that have successfully returned to substantial compliance under temporary management. Specifically, CMS stated it would establish a state-federal workgroup to examine the full array of potential sanctions together, rather than just focusing on temporary management. While our recommendation was limited to the scope of our study—specifically, the use of temporary management—we believe that the agency's actions have the potential to fulfill the intent of our recommendation if they result in an enhanced focus on ensuring that nursing homes remain in compliance.

CMS commented that it did not plan to implement our recommendation that it work with states to create and maintain a list or lists of qualified temporary managers on either a regional or national basis, but the agency stated that it would form a state-federal workgroup to explore this recommendation. Both CMS and AHFSA noted that maintaining such a list posed challenges for several reasons, including the resources required to develop and maintain such a list and differences in state professional licensure laws. Moreover, CMS commented that the creation of the infrastructure to maintain and administer a list of temporary managers presumed that this sanction was both superior to other sanctions and would be used extensively. Our draft report states that many state and regional officials told

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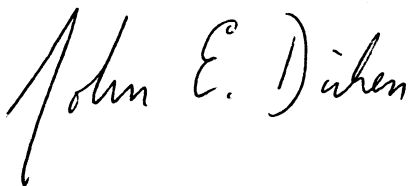
<sup>48</sup>AHFSA represents survey agencies from all 51 states. During the course of our work, we collected information from 47 states. AHFSA agreed to provide us with consolidated comments on our draft report on behalf of all states.

us that the lack of potential temporary managers was an obstacle to using the sanction. Because of the availability of other sanctions that states and regional offices deem more appropriate based on the circumstances and because of the short 23-day time frame to abate immediate jeopardy deficiencies, the availability of a list of temporary managers may not result in significantly greater use of the sanction. Lack of an up-to-date list, however, is clearly an obstacle to the sanction's use when it may be appropriate, an obstacle that is compounded by the short 23-day time frame. As a result, we maintain that the full potential of what CMS characterizes as an important tool will not be fully realized without the development and maintenance of such lists.

AHFSA commented that state laws may vary regarding state authority and procedures involving temporary management. During the course of our study, we asked states whether they had an alternative sanction to federal temporary management and whether they used this alternative from fiscal years 2003 through 2008; we did not review specific state authorities or state procedures for implementing temporary management. AHFSA also noted that one state suggested that CMS conduct a study of the effectiveness of each available federal sanction in ensuring long-term compliance. As noted in our draft report and in CMS's comments, the states and regional offices often use other sanctions in addition to temporary management, such as CMPs and DPNAs. As a result, we believe that it would be difficult to isolate the effectiveness of individual sanctions in ensuring nursing homes' compliance with federal quality requirements.

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As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days after its issue date. At that time, we will send copies to the Administrator of CMS and appropriate congressional committees. The report will also be available at no charge on GAO's Web site at <http://www.gao.gov>. If you or your staff have any questions regarding this report, please contact me at (202) 512-7114 or [dickenj@gao.gov](mailto:dickenj@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Walter Ochinko, Assistant Director; Rebecca Abela; Kaycee M. Glavich; and Elizabeth T. Morrison were major contributors to this report.



John E. Dicken  
Director, Health Care

Enclosures – 4



List of Requesters

The Honorable Herb Kohl  
Chairman  
Special Committee on Aging  
United States Senate

The Honorable Charles E. Grassley  
Ranking Member  
Committee on Finance  
United States Senate

The Honorable Henry A. Waxman  
Chairman  
Committee on Energy and Commerce  
House of Representatives

The Honorable Pete Stark  
Chairman  
Subcommittee on Health  
Committee on Ways and Means  
House of Representatives

The Honorable Jan Schakowsky  
House of Representatives

**Six Nursing Homes Changed Ownership during or after Temporary Management, but Did Not Necessarily Improve; Obstacles to Such Changes May Be Difficult for CMS to Influence**

State officials reported that 6 of the 14 nursing homes that underwent federal temporary management from fiscal years 2003 through 2008 changed ownership either close to the time of or after the sanction's use.<sup>49</sup> Specifically, a change in ownership occurred during or shortly after use of temporary management in 4 of the 6 homes (see enc. III). In all 4 homes, the temporary manager returned the home to substantial compliance and oversaw transition of the change in ownership or remained in place after the change in ownership occurred. At the remaining 2 homes, state officials told us a change in ownership occurred several months or years after the conclusion of temporary management. In 1 of these 2 homes, state officials told us that the home sought a change in ownership during temporary management, but was unable to find a buyer due to an asking price that was higher than potential buyers were willing to pay. The owner sold the home after the state license was revoked and the home reopened under new ownership.

State officials told us that if a nursing home's owner is unwilling to correct or is incapable of correcting immediate jeopardy or other serious deficiencies, a change in ownership may help return a home to compliance and avoid termination. However, a new owner does not necessarily guarantee improvement in the home. Three of the six homes under temporary management from fiscal years 2003 through 2008 that underwent a change in ownership continued to have longer-term compliance problems. Specifically, one of the homes was selected to participate in the Special Focus Facility (SFF) program around the time of the change in ownership, and each of the three homes had one or two stars (much below or below average) in the Centers for Medicare & Medicaid's (CMS) Five-Star Quality Rating System as of August 2009.<sup>50</sup>

State officials primarily identified two obstacles to changing a nursing home's ownership once temporary management has been used, both of which would be difficult for CMS to influence. First, officials noted that when a home subject to temporary management is not financially viable, it is not attractive to potential purchasers. Although this obstacle may be difficult for CMS to address, officials from one state that used the federal temporary management sanction noted that they forced the owner of a home with a high asking price

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<sup>49</sup>A change in a nursing home's ownership can occur at any time, including when federal temporary management is in place or when a nursing home is on track to being terminated. When a change in ownership occurs, the new owner has two alternatives. The new owner can take over the existing provider agreement and be subject to all the terms and conditions under which the existing agreement was issued, including (1) meeting the time frames for correcting deficiencies; (2) assuming responsibility for any sanctions associated with those deficiencies, with two exceptions—the new owner is not (a) subject to the loss of the right to train nurses aides if the nursing home was under a 2-year restriction from the Nurse Aide Training and Competency Evaluation Programs, and (b) responsible for money owed to the federal government due to a determination that the previous owner is personally guilty of fraud; and (3) complying with applicable health and safety requirements. Alternatively, the new owner can apply to participate in Medicare as a new provider and enter into a new provider agreement, which requires enrolling as any other new applicant and undergoing an initial certification survey.

<sup>50</sup>A fourth home had four stars (above average) in the Five-Star Quality Rating System as of August 2009. For the two remaining homes that underwent changes in ownership, we did not report the five-star ratings because the results from at least two surveys that occurred prior to temporary management or while temporary management was in place were included in the calculations of these ratings.

## Enclosure I

that was unable to find a purchaser to lower the price and ultimately a change in ownership occurred. The second obstacle identified—not enough time to find a new owner who can return the home to compliance before termination—is similar to an obstacle that officials cited to imposing federal temporary management. Extending the termination time frame to address this obstacle could lengthen the period of time residents are exposed to the risk of death or serious injury.

**Information on Nursing Homes in Which Federal Temporary Management Was Used,  
Fiscal Years 2003 through 2008**

<b>Nursing home</b>	<b>State<sup>a</sup></b>	<b>Number of certified beds<sup>b</sup></b>	<b>Ownership type</b>	<b>Dates of temporary management</b>	<b>Part of a nursing home chain<sup>c</sup></b>
1	California	62	For-profit	9/2004–1/2005	Yes
2	Colorado	180	Government	12/2003–3/2004	No
3	Colorado	33	For-profit	9/2007–10/2007	No
4	Colorado	120	For-profit	3/2008–6/2008	No
5	Connecticut	130	For-profit	2/2004–12/2004	No
6	Connecticut	330	For-profit	5/2005–4/2006 <sup>d</sup>	No
7	Maine	50	For-profit	8/2006–12/2007	No
8 <sup>e</sup>	Michigan	62	For-profit	4/2005–4/2005	Yes <sup>f</sup>
9	Michigan	142	For-profit	6/2007–7/2007	Yes <sup>f</sup>
10	New Jersey	180	Nonprofit	10/2002– <sup>g</sup>	No
11	South Dakota	108	For-profit	10/2005–2/2006	No
12	Tennessee	122	For-profit	4/2008–1/2009	No
13	Texas	210	For-profit	2/2006–1/2007	Yes
14	Vermont	56	Nonprofit	4/2004–10/2004	No

Source: Centers for Medicare & Medicaid Services' (CMS) On-line Survey, Certification, and Reporting and Providing Data Quickly systems, and state and CMS regional officials.

<sup>a</sup>These states are located in the Atlanta, Boston, Chicago, Dallas, Denver, New York, and San Francisco CMS regions.

<sup>b</sup>As of most recent survey. For homes that have closed, this is the survey prior to closure.

<sup>c</sup>Indicates whether home was part of a nursing home chain at the time temporary management was used. Nursing home chains have two or more homes under one owner.

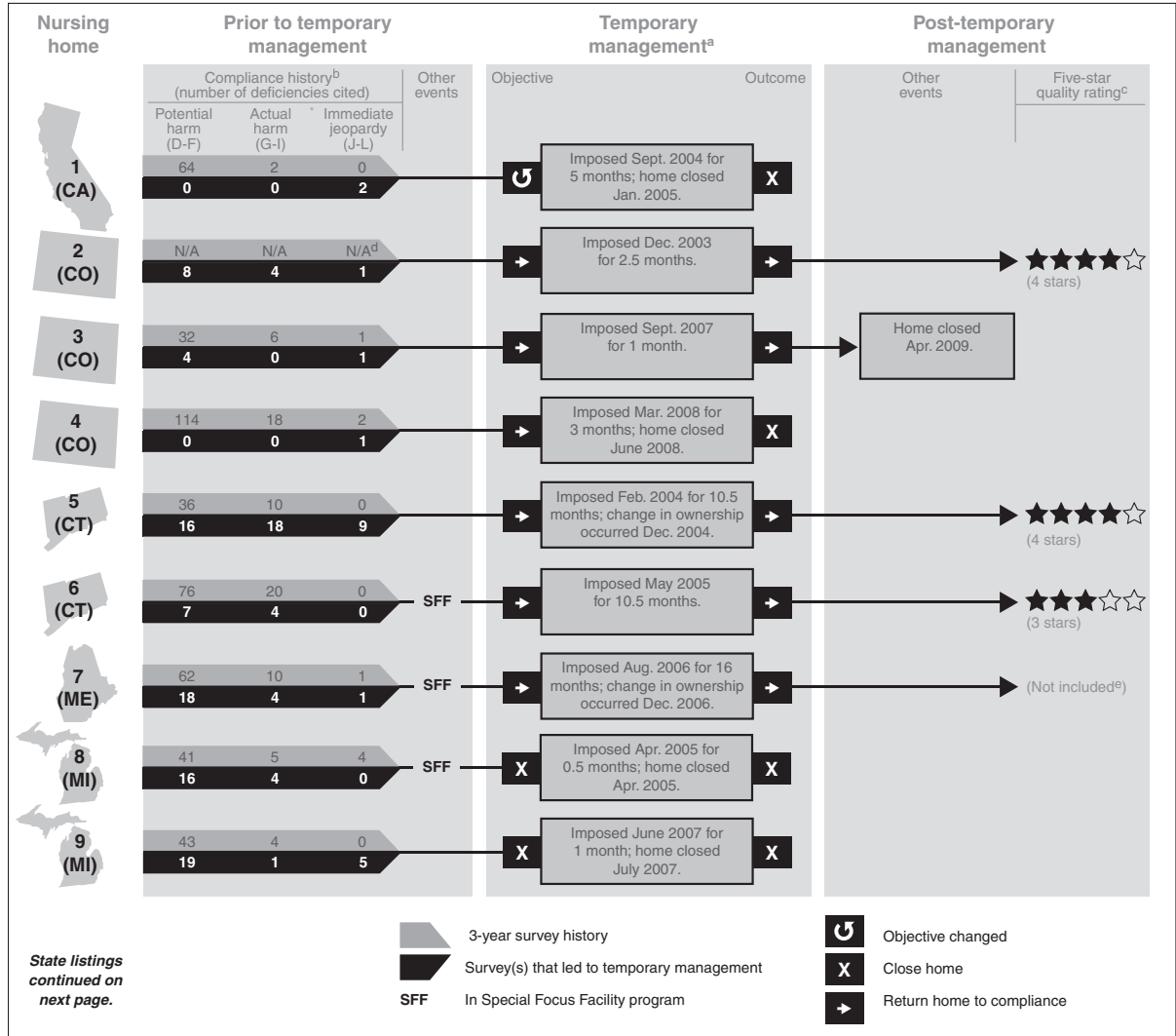
<sup>d</sup>Estimate of duration of temporary management based on responses from state officials.

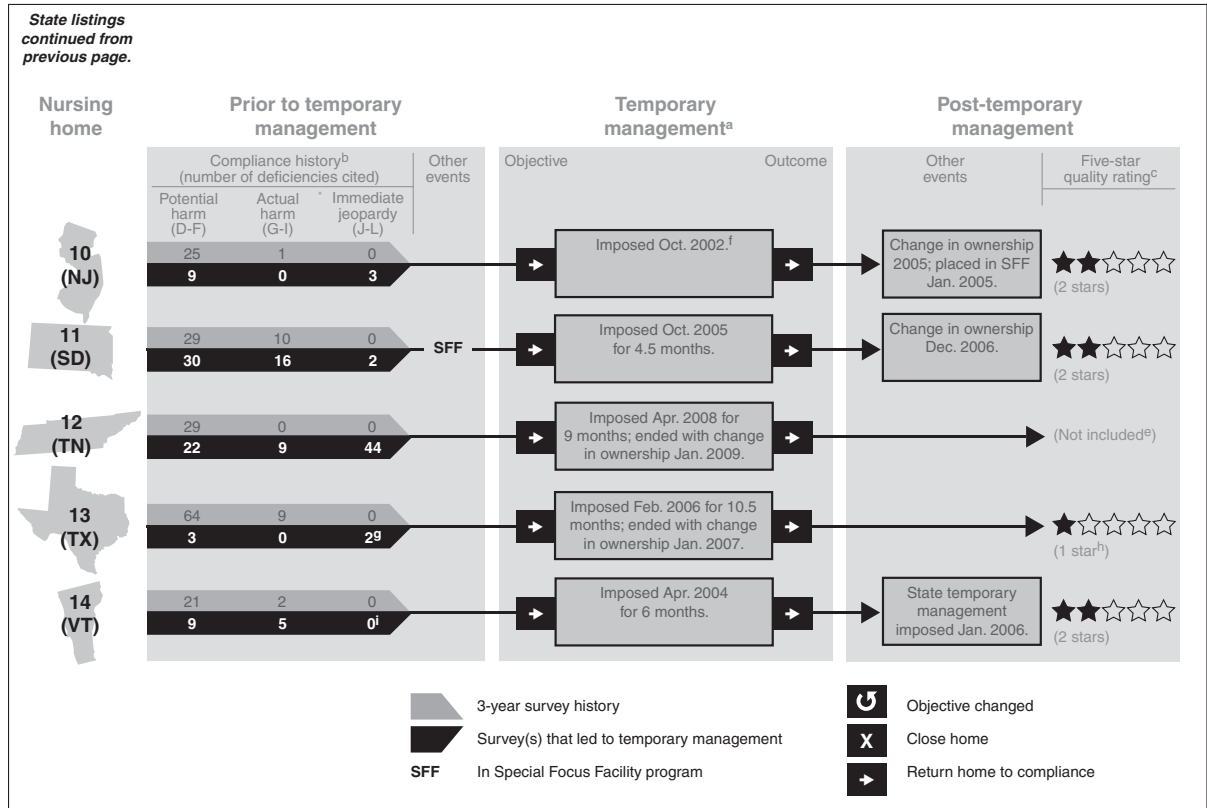
<sup>e</sup>The nursing home only participated in Medicaid, and the state Medicaid agency used the sanction.

<sup>f</sup>These nursing homes had the same owner.

<sup>g</sup>Data on duration of temporary management were not available.

**Nursing Home Compliance History and the Objectives and Outcomes of the Use of Federal Temporary Management, Fiscal Years 2003 through 2008**





Sources: GAO analysis of CMS OSCAR system, PDQ, Nursing Home Compare, and CMS regional office and state officials.

<sup>a</sup>Outcome of temporary management is in the short term.

<sup>b</sup>Three-year compliance history does not include the survey or surveys that led to temporary management.

<sup>c</sup>In December 2008, the Centers for Medicare & Medicaid Services (CMS) began publishing the results from its Five-Star Quality Rating System to help consumers compare nursing homes. Every nursing home in the United States is rated—primarily based on the home's compliance history—with one (much below average), two (below average), three (about average), four (above average), or five (much above average) stars. Ratings presented in the figure are as of August 2009; if a nursing home closed prior to that date or the rating included at least two surveys that occurred during temporary management, it does not have a rating.

<sup>d</sup>Compliance history data prior to imposition of temporary management are not available for 1 of the 14 homes—home number 2—because temporary management was used during the same year the home began participating in Medicare and Medicaid.

<sup>e</sup>We did not report the rating for this home because the results from at least two surveys that occurred prior to temporary management or while temporary management was in place were included in the calculation of this rating.

<sup>f</sup>Data on duration of temporary management were not available.

<sup>g</sup>Includes two surveys conducted immediately prior to temporary management. State officials told us they used these surveys as the basis for recommending temporary management.

<sup>h</sup>CMS's calculation of this home's rating included results from complaint investigations that occurred while temporary management was in place.

<sup>i</sup>Includes two surveys conducted immediately prior to temporary management because they were conducted within 4 days of each other and both led to imposition of temporary management.

**Comments from the Centers for Medicare & Medicaid Services**

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DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation  
Washington, DC 20201

NOV 5 2009

John E. Dicken  
Director, Health Care  
Government Accountability Office  
441 G Street NW  
Washington, DC 20548

Dear Mr. Dicken:

Enclosed are the Department's comments on the U.S. Government Accountability Office's (GAO) draft report entitled: "Nursing Homes: Opportunities Exist to Facilitate the Use of the Temporary Management Sanction" (GAO-10-37R).

The Department appreciates the opportunity to review and comment on this report before its publication.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrea Palm", written over a horizontal line.

Andrea Palm  
Acting Assistant Secretary for Legislation

Enclosure



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

*Administrator*  
Washington, DC 20201

**DATE:** NOV - 5 2009

**TO:** Andrea Palm  
Acting Assistant Secretary for Legislation

**FROM:** Charlene Frizzera  
Acting Administrator *Charlene Frizzera*

**SUBJECT:** Government Accountability Office (GAO) Draft Report "Nursing Homes: Opportunities Exist to Facilitate the Use of the Temporary Management Sanction" (GAO-10-37R)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the above-mentioned draft report. The GAO was asked to gather information as to why the temporary management sanction has been used infrequently to address nursing home quality problems. The GAO focused primarily on two areas:

1. CMS and States' experience with the use of temporary management and its effectiveness in achieving compliance in the short and longer term; and
2. Obstacles to the use of Federal temporary management and how such obstacles could be addressed.

We believe that the GAO study adds value to the important public policy discussions regarding the use of temporary management, one of several remedies provided in the Omnibus Budget Reconciliation Act of 1987 (Pub. Law 100-203). We believe that temporary management is an important tool that States can recommend and CMS can impose in situations of immediate jeopardy (IJ).

The IJ citations in nursing homes are relatively infrequent. For example, the percentage of nursing homes cited for IJ deficiencies ranged from 2.2 percent in 2003 to 2.4 percent in 2006, with a high of 2.6 percent in 2005. Nonetheless, when we identify IJ we take the situation seriously and require that the IJ be remedied within 23 days. It is in this context that temporary managers are used.

In addition to temporary management, CMS makes extensive use of civil monetary penalties (CMPs), denial of payment for new admissions, and termination from Medicare when serious problems persist unremedied. In recent years, we have also taken additional steps to identify those nursing homes most in need of concentrated attention from CMS. Examples include CMS' *Special Focus Facility* initiative, and the *Nursing Home Five-Star Quality Rating System* that is featured on CMS' *Nursing Home Compare* Website. In 2008, CMS also began to require each Quality Improvement Organization to work with at least one special focus facility nursing home in each State.



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The GAO found that infrequent use of temporary management appears to be the result of (1) the availability of other sanctions such as CMPs that States and regional offices deem more appropriate in certain situations; and (2) their determination that many homes can address IJ deficiencies without assistance of a temporary manager. Nonetheless, the GAO made a number of suggestions that might result in greater use of temporary management. We endorse the spirit of the GAO recommendations, but do not fully agree with all of the specific recommendations. We offer the following more detailed responses to the GAO recommendations.

**GAO Recommendation 1: Federal List of Temporary Managers**

To address obstacles to the use of the Federal temporary management sanction, create and maintain a list or lists of qualified temporary managers on either a regional or national basis.

**CMS Response**

We do not plan to implement this recommendation, but will form a State-Federal workgroup to explore the recommendations in this report more fully. It is not simply the creation of such a list that is at issue, but (a) the constant updating of a list of “at-the-ready” potential temporary managers (b) matched to particular geographical areas with (c) particular skill sets that may be needed for (d) a very diverse array of nursing facilities for a (e) sanction (temporary management) that may remain infrequently used even with such a national list. Further, such a system presumes the presence of a Federal infrastructure to maintain and administer a national temporary management program that may be of lower value than alternative uses of staff resources devoted to nursing home oversight and enforcement.

It is also unclear from the GAO analysis whether the use of temporary management is superior or inferior to other forms of enforcement, such as denial of payment for new admissions or CMPs. In fact, it is probable that this question cannot be answered in the abstract, but must be determined based on the specific facts pertinent to each nursing home’s situation. We therefore do not consider it prudent at this time to develop a national temporary management infrastructure based on the presumption that the temporary management remedy is both superior to other remedies and will be extensively used.

Finally, we continue to believe that the most effective venue for maintenance of potential temporary manager lists is at the State level. States generally have licensure and other sanction authority beyond Federal requirements, maintain sanction systems for State licensure violations, and typically have additional oversight responsibilities for providers beyond nursing homes for which temporary managers might be used (e.g., oversight of assisted living facilities). Such State authorities and responsibilities create economies of scale and synergies that make maintenance of lists of local experts at the State level more feasible.

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**GAO Recommendation 2: Best Practices for Use of Temporary Management**

To address obstacles to the use of the Federal temporary management sanction, develop additional information that identifies best practices for States and regional offices, including when and how to use the sanction, the essential qualifications for temporary managers, and alternative funding sources available for temporary management, such as CMP funds.

**CMS Response**

We agree with the recommendation. CMS will seek State best practices, evaluate, and develop additional information to assist States and regional offices in using temporary management. However, the timeline for this activity would need to be determined based on current and anticipated workloads.

**GAO Recommendation 3: Develop Guidance for States to Enhance Oversight**

To help ensure the longer-term compliance of nursing homes that have successfully returned to substantial compliance under temporary management, we recommend that the Administrator of CMS develop guidance for States to enhance their oversight of such homes, such as implementing reactivation of temporary management if the home does not maintain substantial compliance over the 2 years following the conclusion of the sanction.

**CMS Response**

We will explore alternatives to this recommendation in which we consider the full array of potential remedies together, rather than temporary management *per se*. As the GAO report indicates, the choice of using a temporary management sanction in lieu of other remedies is typically occasioned by very specific circumstances in the nursing home. In some cases, for example, it is used to effect an orderly transition of residents to alternate arrangements prior to closure of the nursing home. In other cases, the decision to use temporary management depends on the facility's finances, or an assessment of the capabilities of the current management team, or other factors. While the unique circumstances on the ground are likely to be more important than any general guidance from CMS, we will explore this topic with a State-Federal workgroup.

We appreciate the GAO's interest in ensuring that nursing homes remain in compliance with CMS quality of care and safety expectations once the period of temporary management is ended. This same concern applies to all situations in which serious violations are found, regardless of whether temporary management has been applied. We will therefore explore this issue as well with the State-Federal workgroup.

Other factors not addressed in the GAO recommendations may be important in helping States make more effective use of temporary management. For example, the GAO report found that lack of resources to pay temporary managers was the third most frequently cited barrier to the use of temporary managers.<sup>1</sup> While CMP resources can be an important source of such funding, the GAO

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<sup>1</sup> Table 2, GAO report, questionnaire responses from State survey agencies

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report correctly observes that the Medicare portion of CMP revenue is not available for such a purpose.

Finally, the quality of care in a nursing home depends in part on the actions of the governing body and owner, as well as management team and staff. Whenever the actions of owners or operators represent a significant part of the problem, the use of temporary management has a significant drawback: temporary management can restore the asset value of a nursing home only to have the improved asset placed back in the hands of the same owner or operator that has been party to the decline in quality. The owner may subsequently sell the business (benefiting from the restored value) or continue the pattern of action (or non-action) that gave rise to the problems in the beginning.

These observations suggest that the issue of temporary management is more appropriately viewed in the larger context of creating the best fit between CMS enforcement actions and the root causes of poor quality in a particular nursing home. The best fit will be one that not only restores compliance in the short term, but improves quality in the long term. It is conceivable that such a best fit may involve the use of tools that are not currently in use to any significant extent. These issues require further study. We believe that CMS' *Special Focus Facility* initiative provides a structured program environment within which we can gather additional information about the range of situations and enforcement remedies that should be considered.

## Related GAO Products

*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: Quality of Care More Related to Staffing than Spending.* [GAO-02-431R](#). Washington, D.C.: June 13, 2002.

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