



The Department of Health and Human Services' Office of Inspector General Issued A Report Finding That CMS's Reliance on California's Licensing Surveys of Nursing Homes Could Not Ensure the Quality of Care Provided to Medicare and Medicaid Beneficiaries

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A new report issued by the Department of Health and Human Services' Office of Inspector General (OIG) on June 10, 2014 claims there are serious problems in state licensing and review structures on which the Centers for Medicare & Medicaid Services (CMS) relies in ensuring that thousands of California nursing homes are providing quality care to the state's Medicare and Medicaid beneficiaries. Federal law stipulates that all nursing homes which receive Medicare or Medicaid reimbursement must be licensed in accordance with the legal requirements of the state in which they operate. In California, the Department of Public Health's Licensing and Certification Division conducts licensing surveys every two years to ensure that nursing homes are in compliance with state law. CMS relies on these survey results to determine which California nursing homes maintain a standard of care sufficient to qualify for Medicare or Medicaid reimbursement. In its report, *CMS's Reliance on California's Licensing Surveys of Nursing Homes Could Not Ensure the Quality of Care Provided to Medicare and Medicaid Beneficiaries, A-09-12-02037*, however, the OIG highlights a number of serious deficiencies in California's licensing survey process, and concludes that the process can no longer be trusted to "ensure the quality of care provided to Medicare and Medicaid beneficiaries."

In 2010 and 2011, there were about 130,000 health care and non-health care employees serving more than 13,200 Medicare and 61,800 Medicaid beneficiaries in California nursing homes. For their study, OIG auditors randomly selected from 8 of 1,117 nursing homes, and then randomly selected 30 employees who worked at each nursing home. For each facility, investigators reviewed employee certification and health examination records, licensing survey documentation, and the facility licenses for calendar years 2010 and 2011. The OIG's report focuses on problems discovered in three major areas: (1) nursing homes' compliance with state law regarding employee health examinations and the ability of state surveyors to evaluate such compliance during licensing surveys; (2) the fact that some state licensing surveys were not performed as required; and (3) nursing homes' compliance with state law regarding conditions on the operation of so-called "optional service units" providing certain kinds of specialized care.

California law requires all nursing home employees to undergo a health examination prior to or immediately upon commencement of their employment and once yearly thereafter. This examination has three parts: a physical examination, an evaluation of the employee's medical history, and a tuberculosis test. The investigators' examination of the available records led them to conclude that nursing home employees did not always receive the complete initial and annual health examinations required by California law, that employee health examination records were not always reviewed during licensing surveys of the facilities, and that policy guidance provided to state surveyors did not specify the elements of an employee health examination so that the results of the examination could be effectively evaluated by the surveyors. Of the 240 employees whose files were reviewed, in 59 cases, investigators found that at least one health examination had not provably been conducted when required. In an additional 73 cases, investigators found that one or more of the three elements of the examination had not provably been conducted. Extrapolating from these results, the investigators estimated that 30% of nursing home employees statewide had not received a required health examination, and that 26% had not received at least one element of a required health examination. Review of employee health records was not explicitly required in policy guidance provided to state licensing surveyors but was suggested in supplemental review materials, which nevertheless failed to separately specify the three required elements of the

health examination. At four of the eight nursing homes audited, the state's surveyors failed to review employee health examination records in 2010 or 2011—in two cases, because no licensing survey was conducted at all.

California law separately requires that facilities operating specialized "optional service units" obtain specific state approval for those units and thereafter list the units on their licenses. OIG investigators discovered that these requirements were widely misunderstood and misapplied, both by nursing home administrators and by the state licensing surveyors tasked with overseeing their implementation. Seven of the eight facilities surveyed operated optional service units in the absence of specific approval from the state, while licensing officials responsible for administering state policy explained to the OIG investigators their (incorrect) belief that specific approval was only required under more narrow circumstances than is actually the case under the California law. As a result, during licensing surveys, officials only evaluated those optional service units that were listed on facility licenses, and did not attempt to review whether the facilities had initial or continuing state approval for those units.

The report concludes that California's state licensing survey procedures fail to guarantee the health of—and the quality of care provided to—Medicare and Medicaid beneficiaries. The investigators recommend that facilities implement procedures to enter into compliance with state requirements for employee health examinations and for approval of optional service units; that state licensing officials conduct all surveys required by law and more carefully review employee health records during those surveys; and that the state tighten its licensing review procedures in the identified problem areas. CMS concurred with all of the OIG's recommendations.

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