OIG Office of the Inspector General
SOCIAL SECURITY ADMINISTRATION

Audit Report

Using Nursing Home Data to Determine Suitability of Representative Payees

A-03-16-50056 | March 2018

OIG Office of the Inspector General
SOCIAL SECURITY ADMINISTRATION

MEMORANDUM

Date: March 21, 2018 Refer To:

To: The Commissioner

From: Acting Inspector General

Subject: Using Nursing Home Data to Determine Suitability of Representative Payees (A-03-16-50056)

The attached final report presents the results of the Office of Audit's review. The objective was to determine whether nursing home data could be useful in determining the suitability of representative payees.

If you wish to discuss the final report, please call me or have your staff contact Rona Lawson, Assistant Inspector General for Audit, 410-965-9700.

Gale Stallworth Stone

Gale Stallworth Stone

Attachment

cc:
General Counsel

Using Nursing Home Data to Determine Suitability of Representative Payees
A-03-16-50056

SOCIAL SECURITY ADMINISTRATION
OIG

March 2018 **Office of Audit Report Summary**

Objective

To determine whether nursing home data could be useful in determining the suitability of representative payees.

Background

Congress granted the Social Security Administration (SSA) authority to appoint representative payees to receive and manage payments for individuals who cannot manage or direct the management of their finances. Representative payees can be individuals or organizations. This audit focused on organizational payees that are Medicare/Medicaid-certified nursing homes. SSA uses both internal and external sources to assess the suitability factors for organizational payees.

The Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS) makes available to the public the Nursing Home Compare database and Special Focus Facility Initiative reports that include information for nursing homes that are Medicare and Medicaid certified. The CMS data include (1) health and fire-safety inspection results; (2) a set of measures that describe the quality of care in nursing homes; (3) penalties assessed against nursing homes, such as fines and payment denials; and (4) a list of historically poor performing nursing homes with persistent serious quality issues.

Findings

CMS data could help SSA determine the suitability of organizational payee applicants and existing organizational payees that are nursing homes. Generally, the Agency relies on information provided by organizational payees and monitoring reviews to assess 15 suitability factors. However, these sources were not sufficient in providing the Agency with reliable information to assess four of these factors. However, CMS' nursing home data could provide SSA with useful, relevant, timely, and independent information related to 11 of the 15 suitability factors, including the 4 factors for which the Agency did not have a reliable source for evaluation.

SSA determined that 38 organizational payees were suitable and qualified to serve beneficiaries even though CMS deemed them as chronically underperforming or assessed them the highest fines because of serious and uncorrected deficiencies. From 2012 to 2016, CMS assessed the organizational payees 1,675 deficiencies and issued them $9.5 million in penalties. Further, CMS terminated six of the organizational payees from Medicare/Medicaid for providing substandard quality care; four subsequently closed. SSA conducts monitoring reviews for organizational payees that meet certain criteria. Since 2012, SSA had reviewed 3 of the 38 organizational payees and did not identify any issues that affected their suitability. One of the organizational payees had since closed.

Recommendation

We recommend SSA review and analyze CMS nursing home data to determine whether it can be a tool to assess the suitability of organizational payees that are nursing homes to ensure they are serving beneficiaries' best interests, especially those organizational payees that might not meet SSA's monitoring criteria.

SSA agreed with our recommendation.

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ABBREVIATIONS

C.F.R.	Code of Federal Regulations
CMS	Centers for Medicare and Medicaid Services
CY	Calendar Year
eRPS	Electronic Representative Payee System
FFS	Fee-for-Service
HHS	Department of Health and Human Services
MBR	Master Beneficiary Record
NHC	Nursing Home Compare
OIG	Office of the Inspector General
POMS	Program Operations Manual System
SFF	Special Focus Facility
SSA	Social Security Administration
SSR	Supplemental Security Record
U.S.C.	United States Code

OBJECTIVE

Our objective was to determine whether nursing home data could be useful in determining the suitability of representative payees.

BACKGROUND

Some individuals cannot manage or direct the management of their finances because of their youth or mental or physical impairments. Congress granted the Social Security Administration (SSA) the authority to appoint representative payees to receive and manage these beneficiaries' payments.[1] SSA selects representative payees for Old-Age, Survivors and Disability Insurance[2] and Supplemental Security Income[3] beneficiaries when representative payments would serve the individual's interests. Representative payees are responsible for using benefit payments in the beneficiary's best interests.[4]

A representative payee can be an individual or an organization. For this review, we focused on organizational representative payees that were Medicare/Medicaid-certified nursing homes. Field office staff determine whether an organizational payee applicant is suitable and qualified to serve on a case-by-case basis. When determining suitability, SSA staff consider several factors.

Assessing Representative Payees' Suitability

SSA relies on several sources to assess the suitability of organizational payees, including the payee application,[5] payee interview, and Electronic Representative Payee System (eRPS). The payee application is intended to evaluate a payee's qualifications and suitability to serve. SSA processes the application through eRPS, which acts as an investigative tool helping the Agency fulfill its legal duty to investigate applicants to determine whether a payee appointment is in the best interest of the beneficiary.[6] Field office staff uses the Web-based application to process the payee selections, and the application contains information on accounting, misuse determinations, criminal history, and past payee performance. The payee interview allows SSA staff to gather, document, and address information relative to payees' past performance and criminal history. Payees are generally required to interview for every beneficiary they wish to serve.[7]

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[1] *Social Security Act* §§ 205 (j) and 1631(a)(2). SSA, *POMS*, *GN-General*, ch. GN 005, subch. GN 00502.001 (January 26, 2017).

[2] *Social Security Act* § 201 et seq, 42 U.S.C. § 401 et seq.

[3] *Social Security Act* §§ 1602 and 1611, 42 U.S.C. §§ 1381a and 1382.

[4] SSA, POMS, GN, ch. GN 005, subch. GN 00502.114 (February 27, 2014).

[5] SSA, POMS, GN ch. GN 005, subch. GN00502.107 (June 21, 2017).

[6] SSA, POMS, GN, ch. GN 005, subch. GN 00502.120 (April 15, 2016).

[7] SSA, POMS, GN, ch. GN 005, subch. GN 00502.113, sec. B. (June 23, 2017).

SSA conducts both mandatory and discretionary reviews to ensure payees remain qualified and to protect beneficiaries from misuse. The *Social Security Protection Act of 2004*, Pub. L. No. 108-203, mandates that SSA conduct periodic reviews of fee-for-service (FFS) and volume payees (individuals who serve 15 or more beneficiaries and organizational payees that serve 50 or more beneficiaries).[8] In addition, SSA conducts discretionary reviews (special site review, quick response check, and education visit) based on certain criteria to protect beneficiaries from theft or misuse of benefits. Under its Expanded Monitoring Program, SSA conducts four types of reviews: site, special site, quick response check, and educational visit.

Department of Health and Human Services Nursing Home Data

Nursing homes are required to comply with Federal quality standards to receive payment under the Medicare and Medicaid programs.[9] The Department of Health and Human Services' (HHS) Centers for Medicare and Medicaid Services (CMS) makes available to the public the Nursing Home Compare (NHC) database and Special Focus Facility (SFF) Initiative reports[10] that includes information for Medicare and Medicaid-certified nursing homes. The database and reports are updated monthly and are downloadable or available online to the public at no cost so they can learn how nursing homes perform on health and fire safety inspections, staff with nurses and other healthcare providers, and provide care for their residents.

The NHC database includes (1) health and fire-safety results from the three most recent annual inspections and complaint investigations conducted by State inspectors;[11] (2) a set of measures that describes the quality of care in nursing homes; (3) penalties assessed against nursing homes, such as fines and payment denials; and (4) a list of historically poor performing nursing homes with persistent serious quality issues. Annual inspections are designed to protect the health and welfare of residents and assist with identifying the quality of care provided by a nursing home. If a nursing home does not meet a specific Federal quality standard during an inspection, the facility is issued a deficiency[12] and may be assessed enforcement actions, including penalties and/or termination from Medicare and Medicaid. For each deficiency, State inspectors determine the level of harm to the resident(s) involved and the scope of the problem within the nursing home by assigning an alphabetical scope and severity value, with "A" being the least

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[8] *Social Security Protection Act of 2004*, Pub. L. No. 108-203 § 102 (2004). The mandatory on-site review provisions were incorporated into sections 205(j)(6) and 1631(a)(2)(G) of the *Social Security Act*, 42 U.S.C. §§ 405(j)(6) and 1383(a)(2)(G).

[9] *Social Security Act* §§ 1819 and 1919. 42 C.F.R. part 483, subpart B (1989).

[10] HHS, CMS, *Nursing Home Compare*, medicare.gov (last visited June 29, 2017). HHS, CMS, *Special Focus Facility Report*, medicare.gov (last visited June 29, 2017).

[11] The State inspectors identify violations of Federal requirements, which are based on observations of the nursing home's performance or practices, and make recommendations about appropriate enforcement actions to the appropriate agency. 42 C.F.R. part 483, subpart B (1989) and 42 C.F.R. part 488, subpart F (1994).

[12] A deficiency is identified when a nursing home fails to meet a participation requirement. 42 C.F.R. § 488.301 (2011).

serious and "L" being the most serious rating.[13] Further, the longer the deficiency goes uncorrected, the more severe the enforcement actions could be.

As of July 2016, the NHC database included inspection information as well as enforcement actions for about 15,600 nursing homes nationwide for Calendar Years (CY) 2010 to 2016. While many of the nursing homes may be organizational payees, because SSA does not include a designation for nursing homes in it systems, we were unable to determine how many of the nursing homes were organizational payees. During the 5-year period, CMS assessed the 15,600 nursing homes about 481,000 deficiencies and issued 3,532 nursing homes about $123 million in penalties, ranging from $98 to $1.2 million. According to CMS, most nursing homes average 6 to 7 deficiencies per survey and correct their problems within a reasonable time. For our review, we identified the top 10 nursing homes that were organizational payees and had the highest fines. From the CMS NHC penalty database, we first identified the total fines issued to nursing homes and sorted them in descending order. Then we selected the top 10 nursing homes with the highest fines that were SSA payees by comparing their name, address, and telephone number to eRPS. CMS had issued them about $7 million in penalties (see Table 1). Further, CMS issued the organizational payees 353 violations for failure to comply with regulatory standards. As of June 2016, SSA records showed the organizational payees were serving 254 beneficiaries ranging from 8 to 51 per payee.

In 1998, CMS implemented the SFF Initiative,[14] an 18- to 24-month special program developed to stimulate improvements in the quality of care at nursing homes that have twice the average number of deficiencies that cause harm or injury to residents and are indicative of a pattern of serious issues because they remain persistently uncorrected. Nursing homes selected to participate in the program have three possible outcomes: (1) improved and removed from SFF, (2) extended for showing consistent improvement, or (3) terminated from Medicare/Medicaid. These nursing homes are subject to more frequent on-site State inspections because they chronically underperform.[15] According to CMS, about 50 percent of the nursing homes placed in the SFF program significantly improve their quality of care in 24 to 30 months, while about 16 percent tend to be terminated from Medicare and Medicaid. For the period January to July 2016, there were 137 nursing homes included on the report, of which 129 were organizational payees for SSA beneficiaries.[16] Our review focused on organizational payees that were deemed chronically underperforming. We identified 28 organizational payees that had not improved or were terminated from Medicare/Medicaid for providing substandard care. CMS issued them 1,322 deficiencies for failure to comply with regulatory standards and $2.5 million in penalties

[13] For a full description of the deficiency rating, see Appendix C.

[14] HHS, CMS, SC Letter 05-13, *Improving Enforcement via the Special Focus Facility Program for Nursing Homes*, December 16, 2004.

[15] *Social Security Act* § 1819 (f)(8).

[16] The SFF provides for a designated number of slots; therefore, the list is not all-inclusive of the worst nursing homes.

for serious or uncorrected deficiencies (see Table 1). As of June 2016, SSA records showed that 25 of the 28 organizational payees were serving 487 beneficiaries ranging from 1 to 59 per payee.

Table 1: Sample Payee Included in CMS Reports

CMS Reports	Payee Status	SSA		CMS	
		Payees	Beneficiaries	Deficiencies	Fines
NHC	Highest Fines	10	254	353	$7,008,154
SFF	Unimproved	25	487	1,162	$2,121,903
	Terminated	3	-	160	377,130
Subtotal		28	487	1,322	$2,499,033
Total		**38**	**741**	**1,675**	**$9,507,187**

RESULTS OF REVIEW

The CMS nursing home data could help SSA assess the suitability of organizational payees that are Medicare/Medicaid-certified nursing homes. Generally, the Agency relies on information provided by the organizational payees via the payee application, interview, and information in its systems to assess 15 suitability factors.[17] SSA also conducts monitoring reviews to ensure existing organizational payees remain suitable. These sources did not sufficiently provide the Agency with valuable and reliable information needed to assess 4 of these 15 factors. However, CMS' nursing home data could provide SSA with useful, relevant, timely, and independent information related to 11 of the 15 suitability factors, including the 4 factors for which the Agency did not have a reliable source for evaluation.

SSA had determined that 38 organizational payees that were nursing homes were suitable and qualified to serve beneficiaries even though CMS deemed them as chronically underperforming or assessed them the highest fines because of serious and uncorrected deficiencies. CMS found the services they provided violated Federal regulatory requirements,[18] and some violations caused harm or immediately jeopardized residents' health or safety. As a result, from 2012 to 2016, CMS assessed the organizational payees 1,675 deficiencies and issued them $9.5 million in penalties. Further, CMS terminated six of the organizational payees from Medicare/Medicaid for providing substandard quality care—four of these subsequently closed. Since 2012, SSA had not conducted monitoring reviews for 35 of the 38 organizational payees because they did not meet the criteria for mandatory or discretionary monitoring reviews. The Agency conducted monitoring reviews for three organizational payees and did not identify any issues that affected their suitability. One of the organizational payees had since closed.

[17] See Appendix E for sources used for suitability factors.

[18] 42 C.F.R § 483.10 through 42 C.F.R §483.75.

Suitability Factors

SSA considers and weighs 15 factors to assess the suitability of payee applicants and existing organizational payees because this determination may affect a beneficiary's quality of life (see Table 2).[19] Generally, the Agency obtains information from the payee application, the interview, and eRPS to assess the suitability of an organizational payee. However, these sources did not always provide enough information for SSA staff to evaluate 4 of the 15 suitability factors for nursing homes that apply to be an organizational payee for the first time. Specifically, the payee application lacked questions that allowed SSA staff to determine whether an applicant had effective internal communication, sound financial management, adequate staff and resources, and stable community presence. Most questions related to individual rather than organizational payees. While SSA staff may ask additional questions during the payee interview that are not on the application, they are less likely to do so because it is optional.[20] Although eRPS documents past allegations and monitors review results that could identify weaknesses related to the four suitability factors that are assessed as part of the monitoring reviews, these findings only relate to existing organizational payees—not new payee applicants.

According to SSA employees, they evaluate the four suitability factors for organizations that apply to be FFS payees, which represent about 4 percent of the total SSA organizational payees. The Agency obtains information from the FFS application[21] and credit reports from Dun and Bradstreet to assess the four suitability factors. For example, the FFS application contained at least two questions to determine whether an applicant has adequate staff and resources—the maximum number of beneficiaries they serve and the number of employees who handle affairs for the SSA beneficiaries. SSA obtains credit reports from Dun and Bradstreet when a nongovernmental agency applies to become an FFS payee because the reports provide the Agency with a better understanding of potential risk factors associated with business losses due to fraud, failure, or severe delinquencies.[22] SSA policy does not limit the four suitability factors to FFS payees; it indicates the suitability factors apply to all organizational payees, which would include nursing homes.[23] Thus, the Agency should be evaluating these four suitability factors for nursing homes that apply to become an organizational payee.

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[19] SSA, POMS, GN-General, ch. GN 005, subch. GN 00502.130, sec. B.1 and B.3 (January 31, 2006). SSA, POMS, GN-General, ch. GN 005, subch. GN 00502.132, sec. A (October 31, 2017).

[20] Some SSA regional offices developed guides to assist staff with the types of questions to ask during the interview; however, these guides are not policy, and the responses may not be documented in SSA records.

[21] SSA-445, *Application To Collect A Fee For Payee Services*, (07-2006), SSA, POMS, GN-General, ch. GN005, subch. GN 00506.110 (April 15, 2016).

[22] SSA, POMS, GN-General, ch. GN 005, subch. GN 00506.600, sec. A (August 30, 2016).

[23] SSA, POMS, GN-General, ch. GN 005, subch. GN 00502.130, sec. B.3 (January 31, 2006).

For existing nursing homes that are organizational payees, SSA assesses three of the four suitability factors using information from its monitoring reviews, but, for three of the factors, SSA focuses on responses to its Expanded Monitoring Program Site Review Questionnaire.[24] SSA uses this Questionnaire as part of a mandatory or discretionary monitoring review. According to SSA, the Questionnaire contains specific questions that allow it to determine whether the payee has effective internal communications, sound financial management policies, and adequate staff and resources. For example, SSA evaluates effective internal communication by requesting a copy of an organizational payee's internal written guidelines for managing beneficiary funds. In addition, SSA requests the names and titles of employees who receive and process benefit payments, determine beneficiary needs, and monitor resources to determine whether organizational payees have adequate staff to serve clients. Further, they request that these individuals be available during the onsite reviews. However, the Questionnaire is only beneficial if an organizational payee is subject to a mandatory or discretionary monitoring review. For the 38 organizational payees we sampled, SSA had not conducted monitoring reviews of 35 since at least 2012. We discuss this in the Sample Organizational Payees section of this report.

Table 2: Suitability Factors Considered for Nursing Home Organizational Payees

SSA				CMS
Factors	**Suitability Factor Description**	**Initial Selection**	**Monitoring**	
1	Effective Internal Communication		✓	✓
2	Sound Financial Management Policies		✓	✓
3	Adequate Staff/Resources to Serve Clients		✓	✓
4	Stable Community Presence		✓	✓
5	Protected Fund Accounts	✓	✓	✓
6	Adequate Recordkeeping Systems to Ensure Client Needs are Met	✓	✓	✓
7	Voluntary Direct Deposit	✓	✓	
8	Concern for Beneficiary's Well-being	✓	✓	✓
9	Knowledgeable of Beneficiary's Needs	✓	✓	✓
10	Exercise Good Judgment in Beneficiary's Best Interest	✓	✓	✓
11	Beneficiary Custody	✓	✓	
12	Applicant/Beneficiary Financial Relationship (creditor)	✓	✓	
13	Misuse of Benefits	✓	✓	
14	Payee Past Performance	✓	✓	✓
15	Criminal History[1]	✓	✓	✓
Total		**11**	**15**	**11**

Note 1: SSA reviews the criminal history of individual representative payees—not organizational payees or their employees. CMS has a standard that focuses on the criminal histories of a nursing home's employees.

[24] Form SSA-637, *Expanded Monitoring Program Site Review Questionnaire for Volume and Fee for Service Payees* (12-2016).

CMS Data as Supplementary Sources

Our review of CMS' nursing home data showed it could provide SSA with useful, relevant, timely, and independent information related to 11 of the 15 suitability factors, including the 4 for which SSA did not have a reliable source for evaluating organizational payees that were nursing homes (see Table 2). In addition, CMS data contained State licensing and penalty information for nursing homes that could be useful to SSA. Our comparison of the CMS nursing home data and SSA suitability factors are included in Appendix D. Below, we discuss 6 of the 11 suitability factors.

Effective Internal Communication: SSA determines whether there is good communication between an organization's case management and financial management components. This is essential because it helps ensure caseworkers are aware of changes in beneficiaries' needs as well as financial records. CMS had at least three regulatory standards that related to the effectiveness of a facility's internal communications. The regulatory standards require that nursing homes (1) notify residents and appropriate parties about transfers and discharges; (2) inform residents and appropriate parties of situations (injury/decline/room, etc.) that affects the resident's well-being; and (3) transfer, upon a resident's death, the resident's personal funds and an accounting of those funds to the appropriate party. For example, CMS determines whether a facility has transferred, within 30 days of a resident's death, the resident's personal funds, and a final accounting to the person or probate jurisdiction that administers the resident's estate, as provided by State law. To ensure this occurs, a nursing home needs to have effective communication between case management staff responsible for the residents and the financial management staff responsible for billing and residents' financial records. A payee is responsible for returning to SSA any benefits to which the beneficiary is not entitled, such as payments made for deceased beneficiaries.[25]

Sound Financial Management Policies: SSA determines whether an organization has sound financial management policies to ensure they are current with their financial obligations. If an organizational payee is struggling to meet its own financial obligations, there is an increased risk the payee may not use SSA benefits for the beneficiary's best interests. The Agency should consider using CMS' NHC database to help evaluate an organizational payee's financial management policies since the database includes penalty data. CMS imposes penalties on a nursing home when a serious deficiency is cited during an inspection or if the nursing home fails to correct a deficiency for a long period. Penalties include fines and payment denials. Fines may be imposed per deficiency instance or each day until the nursing home corrects the deficiency. When payments are denied, CMS stops Medicare and Medicaid payments until the nursing home corrects the deficiency. As of July 2016, CMS data showed that 3,532 nursing homes were issued fines totaling about $123 million, ranging from $98 to $1.2 million. Over 300 of the nursing homes were assessed fines that exceeded $100,000 for failure to meet regulatory standards. Furthermore, CMS issued payment denials to about 1,200 nursing homes, of which

[25] SSA, POMS, GN, ch. GN 005, subch. GN 00502.114, sec. A (February 27, 2014). SSA, POMS, GN, ch. GN 024, subch. GN 02408.007, sec. A (October 28, 2013).

55 had payment denials for 3 months or longer. High fines or payment denials could indicate an organizational payee may not be able to meets its own financial obligations.

Adequate Staff/Resources to Serve Clients: The Agency established a suitability factor to determine whether an organizational payee had adequate staff and resources to serve beneficiaries. This is important because beneficiaries' health and welfare could be negatively affected if a payee does not have the appropriate number of qualified staff. CMS had at least four regulatory standards related to this suitability factor. CMS requires that nursing homes (1) employ sufficient nursing staff to care for every resident in a way that maximizes the resident's well-being; (2) administer the facility in a manner that enables it to use its resources effectively and efficiently; (3) employ staff that is licensed, certified, or registered in accordance with State laws; and (4) employ or obtain outside professional resources to provide services when the facility does not employ a qualified professional to furnish a required service. Noncompliance with these regulatory standards could indicate an organizational payee or applicant may not have the appropriate staffing and resources to meet beneficiaries' needs.

Stable Community Presence: SSA determines whether an organizational payee has a stable community presence to ensure the organization is not likely to go out of business. SSA evaluates this factor as part of its monitoring reviews for existing organizational payees. During these reviews, SSA may analyze the representative payee's most recent financial statements (balance sheet and income statement) to determine the organizational payee's solvency. Not all organizational payees may be subject to a monitoring review. On the other hand, CMS has regulatory standards and other information that could be useful in determining whether an organizational payee has a stable presence in the community. CMS requires that nursing homes operate with a valid license and provide services in accordance with Federal, State, and local laws and professional standards. If a nursing home fails to comply with these two standards, CMS could terminate it from the Medicare and Medicaid programs, which may affect its ability to remain solvent. Further, CMS' SFF report could be useful because it identifies nursing homes that are deemed chronically underperforming and have significant quality issues. Nursing homes remain on the SFF report until they comply with regulatory standards or are terminated from Medicare and Medicaid for failure to improve. This report could be analyzed to determine whether it can be used as an early indicator to SSA in determining whether organizational payees should be subject to a monitoring review to ensure they are stable and can continue meeting beneficiaries' needs.

Protected Fund Accounts: SSA determines whether organizational payees are holding beneficiaries' payments in protected accounts. This is intended to ensure bank accounts are protected from unauthorized use. SSA verifies that organizational payees are holding funds in protected accounts during monitoring reviews and through annual accounting reports submitted by organizational payees. The Agency ensures the titling of bank accounts or sub-accounts shows the payee has only a fiduciary interest in the accounts, and the beneficiary owns the funds. As part of the annual inspection, CMS verifies that nursing homes have properly held, secured, and managed beneficiaries' personal funds. SSA should consider reviewing this information because it may help prevent the mismanagement of beneficiaries' benefits. Further, for new payee applicants, a deficiency in the area could alert SSA to problems that require monitoring.

Criminal History: The *Social Security Act,* Federal regulation, and SSA policy contain provisions to prevent individuals convicted of certain crimes from serving as representative payees.[26] SSA documents in eRPS whether a person has been convicted of violating certain sections of the *Social Security Act* or has a history of criminal activity. Most of the criminal information relates to individual rather than organizational representative payees. SSA may receive criminal information for individual payees from our Office of Investigations as well as allegations from other sources, such other governmental agencies. However, SSA has no established business process to obtain criminal information for employees of organizational payees. In contrast, CMS has a regulatory standard that focuses on criminal and abuse activity related to nursing home employees. This is especially important because employees generally have physical access to beneficiaries and their benefit payments. Specifically, State inspectors determine whether nursing homes employ individuals who have (1) been convicted of abuse, neglect, exploitation, misappropriation of property, or mistreatment of residents; (2) had a finding entered into the State nurse aide registry concerning these factors; or (3) a disciplinary action in effect against his/her professional license by a State licensure body as a result of a finding of these factors. Knowing an organizational payee employs individuals who have criminal or abuse histories could be beneficial to SSA in its suitability determination. Additionally, the information could be used as an early indicator to conduct monitoring reviews to help prevent potential harm to beneficiaries who are in these organizational payees' care.

Sample Organizational Payees

We reviewed 38 SSA organizational payees that were serving 741 beneficiaries, which ranged from 1 to 59 per payee, and that CMS had identified as being chronically underperforming or assessed significant monetary penalties. CMS had placed 28 of the payees on the SFF report for chronically underperforming and issued 10 payees the highest monetary penalties for serious and uncorrected deficiencies. From CYs 2012 to 2016, CMS assessed these payees 1,675 deficiencies for failure to comply with regulatory requirements and issued about $9.5 million in penalties because of the severity or scope of the deficiencies or the failure to rectify them. The 38 organizational payees had 273 deficiencies that were deemed to cause actual harm or immediate jeopardy to residents' health and safety, ranging from 1 to 23 violations per payee (see Figure 1).[27] For example, 15 organizational payees had deficiencies related to abuse or employing individuals guilty of abuse that were deemed to cause actual harm or immediate jeopardy to resident's health and safety.

In addition, the 38 organizational payees had deficiencies that related to 9 of the 15 factors SSA uses to assess the suitability and qualifications of organizational payees. Specifically, 368 deficiencies related to SSA's suitability factors, of which 112 were deemed to cause actual harm or immediate jeopardy to residents' health and safety.

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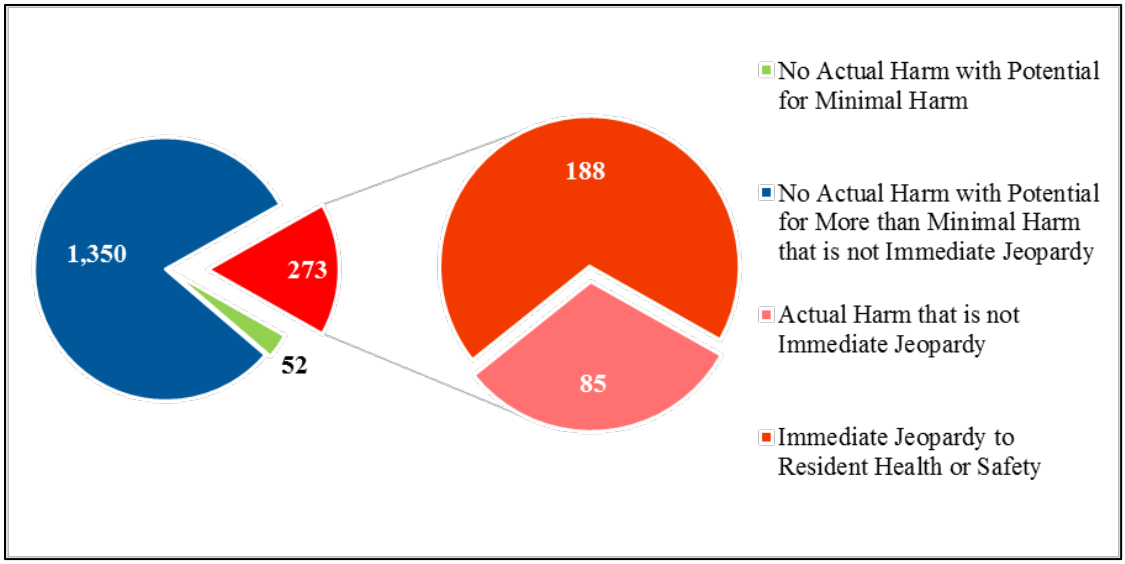
[26] *Social Security Act* §§§ 208(d), 811, and 1632(a), 42 U.S.C §§§ 408, 1011, and 1383a. SSA, POMS, GN-General, ch. GN 005, subch. GN 00502.133, sec. A.1 (June 23, 2017). Pub. L. No. 108-203 §103. 20 C.F.R. § 416.622 (2017).

[27] For a list of total deficiencies issued to the 38 organizational payees, see Appendix F.

Moreover, since 2012, SSA had not conducted monitoring reviews for 35 of the 38 organizational payees because they did not meet the criteria for mandatory or discretionary monitoring reviews. They were not subject to a mandatory review because none of them was designated an FFS or volume payee. Further, they were not subject to a special site review, which is based on the likelihood of a payee misusing benefits, or a quick response check, which is based on a trigger event, such as adverse media. SSA had conducted monitoring reviews for three organizational payees but did not identify significant issues related to the beneficiaries' health and safety.

Figure 1: Sample Organizational Payees' Deficiencies by Severity



Source: CMS (July 2016)

Special Focus Facility Initiative Report

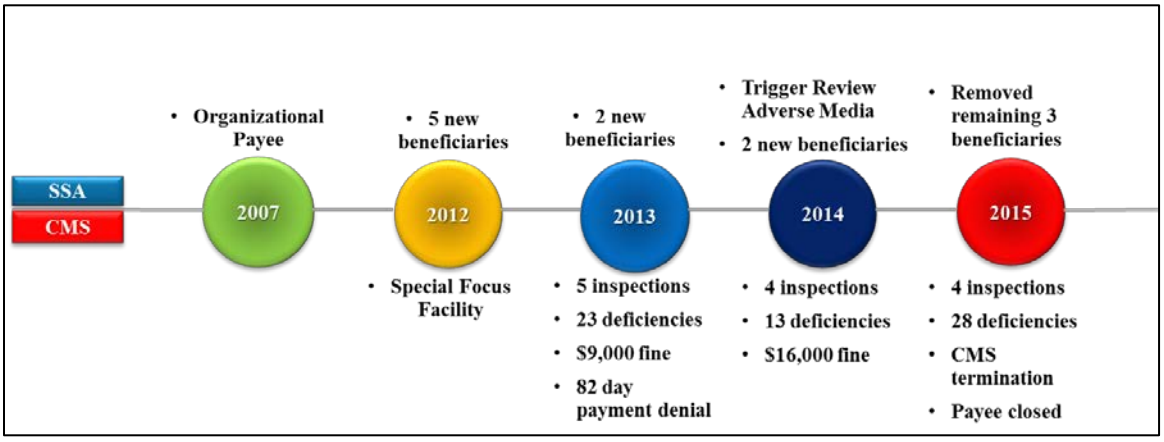
As of July 2016, 28 organizational payees were listed on CMS' SFF report from 4 months to almost 4 years for not showing improvement or were terminated from Medicare and Medicaid for providing sub-standard care. These organizational payees were assessed 1,322 deficiencies for noncompliance with regulatory standards. Of these, 178 were deemed to cause actual harm or immediate jeopardy to a resident's health or safety. We determined that 81 of these deficiencies pertained to (1) adequate staff and resources, (2) concern for beneficiary's well-being, (3) criminal history, and (4) effective internal communication. In addition, these organizational payees were issued about $2.5 million in penalties and denied Medicare and Medicaid payments because they did not take corrective actions. The fines ranged from $1,105 to $350,000, and the payment denials ranged from 6 to 198 days. Further, the organizational payees were serving 487 beneficiaries but were not complying with the regulatory standards. SSA had assigned them 167 beneficiaries after CMS placed them on the SFF report.

As of July 2016, 3 of the 28 organizational payees had been terminated from Medicare and Medicaid participation because they had not shown improvement and remained noncompliant with regulatory standards. By June 2017, CMS had terminated two additional organizational payees from Medicare and Medicaid for persistent poor performance. Four of these five payees

have since closed. We did not find evidence in SSA records that it was aware of the organizational payees' histories of noncompliance with regulatory standards and closures until benefit payments were returned to the Agency when the facilities closed. At that point, SSA had to find more suitable payees for the beneficiaries that were in the organizational payees' care.

From January 2012 to July 2017, SSA conducted monitoring reviews for 2 of the 28 organizational payees and concluded they were suitable. The Agency determined the organizational payees had properly managed beneficiaries' funds, and the beneficiaries' needs were being met. For example, an organizational payee in Iowa that had been serving for about 8 years was placed on the SFF report in June 2012 to help improve its performance (see Figure 2). Over the 8-year period, it cared for 20 SSA beneficiaries. Nine of the 20 beneficiaries were assigned to the payee between 2012 and 2014—after the organization was placed on the SFF report for poor performance. Between April 2013 and July 2015, State inspectors conducted 13 inspections and assessed 64 deficiencies for noncompliance with regulatory standards, of which 3 were deemed to have caused actual harm. Of these, 15 violations related to (1) adequate staff and resources, (2) criminal history, (3) effective internal communication, (4) knowledge of beneficiary's current and foreseeable needs, (5) stable community presence, and (6) concern for beneficiary's well-being. For example, an NHC inspection report showed the payee failed to provide residents the appropriate level of care, which led to residents having open wounds that became infected or deformed and required continuous monitoring to prevent the loss of limbs. Furthermore, in 2013 and 2014, the payee was assessed a payment denial that lasted 82 days and two fines totaling about $25,000. From June to September 2014, SSA conducted a trigger review of the organizational payee because of adverse media attention for poor conditions and concluded no issues were found.[28] However, 1 year later, in September 2015, the organizational payee closed after CMS terminated it from Medicare and Medicaid. SSA terminated the organizational payee in October 2015 after it returned benefit payments to the Agency and assigned the remaining three beneficiaries to new payees.

Figure 2: Iowa Nursing Home on SFF Report



[28] Tim Johnson, *Regency Rehab and Skilled Nursing faces fine amidst upgrades*, nonpareilonline.com (March 29, 2014).

Top 10 Organizational Payees with the Highest Fines

In CYs 2012 to 2016, CMS assessed 10 organizational payees the highest monetary penalties because of the severity and scope of their deficiencies. As of June 2016, they were serving 254 SSA beneficiaries.[29] The 10 organizational payees were issued 17 fines, totaling about $7 million, ranging from $564,000 to $1.2 million. In addition, 8 of the 10 organizational payees were denied Medicare and Medicaid payments 9 times because they failed to return to substantial compliance within 3 months. The payment denials ranged from 1 to 129 days. For the 10 organizational payees, State inspectors identified 353 deficiencies, of which 95 were deemed to cause actual harm or immediate jeopardy to residents' health or safety. Of the 95 deficiencies, 69 related to 7 SSA suitability factors, such as adequate staff and resources, criminal history, and effective internal communication.

Of the 10 payees, SSA had conducted a monitoring review for 1 volume organizational payee. The May 2016 report showed the organizational payee had (1) failed to return conserved funds[30] to SSA when the payee relationship was terminated, (2) improperly recorded beneficiary expenses, and (3) failed to have a reconciliation policy for checks outstanding longer than 90 days. SSA records indicated these issues were resolved, and the organizational payee remained suitable. From August 2014 to October 2015, CMS assessed the organizational payee 3 fines totaling about $1 million for 36 serious or uncorrected deficiencies, of which 20 were deemed to have caused actual harm or immediate jeopardy to residents' health or safety. Violations assessed included the organizational payee's failure to protect each resident from mistreatment, neglect, and misappropriation of personal property and ensure the facility was administered in a way that maintained each resident's well-being.

The remaining nine organizational payees were not subject to an SSA monitoring review because they did not meet the selection criteria for the mandatory or discretionary reviews. Yet CMS assessed them the highest fines for failure to correct serious or outstanding deficiencies. For example, in 2015, CMS issued an organizational payee in Tennessee who had been appointed payee for 121 beneficiaries since October 2000 the highest monetary penalty (see Figure 3). Between August 2013 and January 2017,[31] State inspectors conducted 10 inspections and assessed 78 deficiencies for noncompliance with regulatory standards. Seven of these deficiencies related to (1) adequate staff and resources, (2) concern for beneficiary's well-being, and (3) knowledge of beneficiary's current and foreseeable needs. For example, according to the February 2015 NHC inspection report, the nursing home did not provide necessary incontinent care to change and bathe the residents, and wash residents' clothes, which resulted in some residents having a strong odor of urine on their bodies and belongings as well as in the areas they

[29] As of April 2016, 1 of the 10 organizational payees stopped serving as an SSA payee because the beneficiaries were assigned to a more suitable payee.

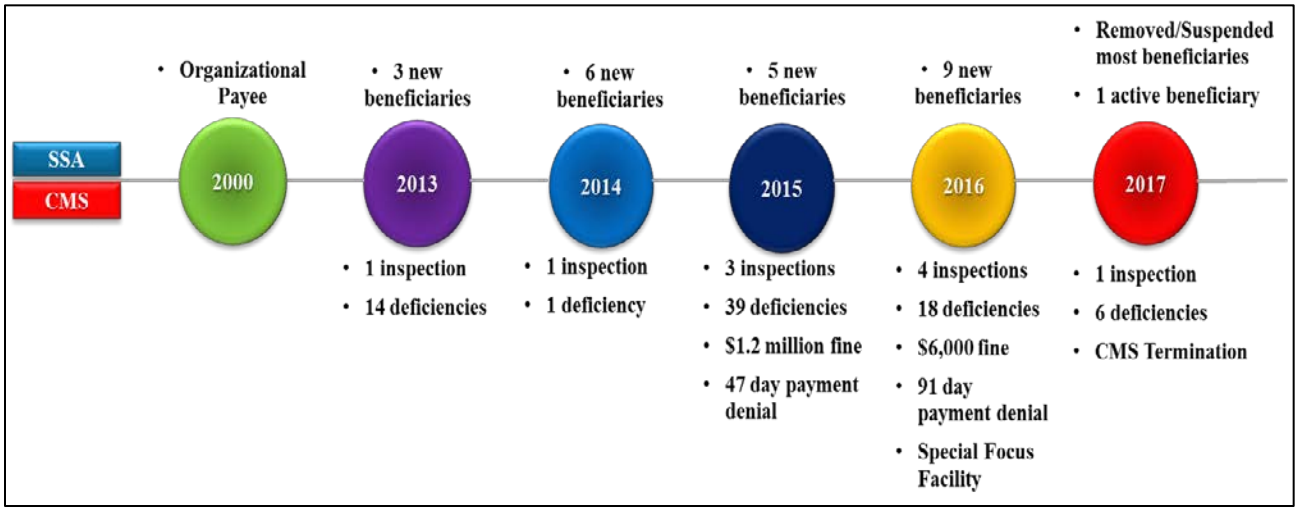
[30] Benefits must be used for the immediate or reasonably foreseeable needs of the beneficiary. Any remaining funds must be conserved or invested for the beneficiary. SSA, POMS, GN-General, ch. GN 006, subch. GN 00603.001, sec. A (November 15, 2004).

[31] Nursing Home Compare deficiency data for organizational payee in Tennessee obtained in June 2017.

occupied. In addition, the organizational payee failed to ensure only medications that had a physician/nurse practitioner order were administered, weekly skin assessments were done for residents at risk of impaired skin integrity, and necessary services were provided to avoid physical harm and mental anguish to residents for incontinence and/or rehabilitation care. Because of these findings and other deficiencies, CMS[32] assessed the organizational payee a $1.2 million fine.[33]

In 2015 and 2016, the organizational payee was assessed two payment denials that lasted 138 days (47 days in 2015 and 91 in 2016). The organizational payee failed to obtain substantial compliance, which led CMS to place it on the July 2016 SFF report. After it was on the SFF report for only 8 months, in March 2017, CMS terminated it from Medicare and Medicaid for failing to show improvement.[34] While the organizational payee was having significant noncompliance issues with the regulatory standards and issued multiple penalties, SSA records did not indicate the Agency was aware of the organizational payee's poor performance. Further, the payee was not subject to any monitoring reviews during this time. As of March 2017, the organizational payee had nine beneficiaries in its care, and SSA subsequently removed most of them over the next 4 months, between April and July 2017.

Figure 3: Tennessee Nursing Home with Highest Fine



[32] See Appendix G for an excerpt of the information CMS provides on its NHC Website.

[33] Emily Mongan, *Nursing home pays $1.2 million fine following 35 deficiencies*, mcknights.com (August 30, 2015).

[34] Zaneta Lowe, *Signature Healthcare at Saint Francis nursing home to lose funding*, wreg.com (April 3, 2017).

CONCLUSIONS

The nursing home data CMS maintains could be a reliable source for SSA when it determines the suitability and qualifications for new organizational payee applicants as well as existing organizational payees that are Medicare/Medicaid-certified nursing homes. We determined the CMS data could assist SSA with assessing 11 of the 15 factors it uses to determine whether an organization is suitable to serve as an organizational payee. SSA staff was not aware of the CMS data but also was not aware of any policy that would prevent the Agency's use of the data for suitability determinations.

RECOMMENDATION

We recommend that SSA review and analyze CMS nursing home data to determine whether it can be a tool to assess the suitability of organizational payees that are nursing homes to ensure they are serving beneficiaries' best interests, especially those organizational payees that might not meet SSA's monitoring criteria.

AGENCY COMMENT

SSA agreed with our recommendation. The Agency's comments are included in Appendix H.

Rona Lawson
Assistant Inspector General for Audit

APPENDICES

Appendix A – Scope and Methodology

To accomplish our objective, we:

- Reviewed applicable Federal laws and sections of the *Social Security Act* and Social Security Administration's (SSA) regulations, policies, and procedures.
- Reviewed applicable Program Operations Manual System policies and operating instructions relevant to our organizational payees and suitability.
- Reviewed Office of the Inspector General (OIG) reports, Government Accountability Office reports, and other relevant documents.
- Obtained data extracts from SSA's Master Beneficiary (MBR) and Supplemental Security Records (SSR) as of June 2016 to identify the number of beneficiaries the organizational payees were serving.
- Obtained data extracts from SSA's electronic Representative Payee System (eRPS) as of September 2015.
- Downloaded the Centers for Medicare & Medicaid Services' (CMS) Nursing Home Compare (NHC) data as of July 2016 and identified the following five databases. The data are updated on or before every fourth Wednesday of the month.
    - Deficiencies: A list of 481,164 deficiencies for nursing homes and the associated inspection date, deficiency tag number, scope and severity, deficiency status, and correction date.
    - Ownership: A list of 180,980 records showing ownership information for active nursing homes.
    - Penalties: A list of the fines and payment denials issued to nursing homes. There were 6,465 records.
    - Provider Information: General information on active nursing homes, including number of certified beds, quality measure scores, staffing, and other information used in the Five-Star Rating System. There were 15,646 records.
    - MDS Quality Measures: A list of the quality measures displayed on NHC, excluding measures of re-hospitalization, emergency room visits, and community discharge. Each row contains a specific quality measure for a specific nursing home and includes the three-quarter score average and the score for each individual quarter. There were 328,566 records for long-term stays and 46,938 records for short-term stays.
- From the CMS NHC penalty database, we first identified the total fines issued to nursing homes and sorted them in descending order. Then, we selected the top 10 nursing homes with the highest fines that were SSA payees by comparing their name, address, and telephone number to eRPS.
- Downloaded CMS' Nursing Home Compare Special Focus Facility (SFF) Initiative reports issued January 21 and July 21, 2016. The report is updated on the fourth Thursday of every month.

- Identified 137 nursing homes on the report, of which 129 were SSA organizational payees.
- We compared SSA's eRPS organizational payee information that included the organization's name, address, and/or telephone number to CMS facility name, location, and/or telephone and selected for review 28 nursing homes that were SSA organizational payees and had not shown improvement or were terminated from Medicare and Medicaid participation for providing substandard quality care.

- Identified and compared SSA's organizational suitability factors to CMS' standards to identify the standard most directly related.
- For the 38 organizational payees selected for review, we
  - reviewed the MBR, SSR, and eRPS to determine whether the payees were serving beneficiaries;
  - determined whether the payee selections occurred before or after payees were placed on the SFF report, if applicable;
  - reviewed deficiency and penalty information;
  - reviewed the Representative Payee Monitoring Application to determine whether payees were subject to monitoring reviews; and
  - reviewed media reports to identify issues about organizational payees.

We conducted this audit at the Philadelphia Audit Division, Philadelphia, Pennsylvania, from January through September 2017. We tested the data obtained for our audit and determined they were sufficiently reliable to meet our objective. The entities reviewed were the Offices of the Deputy Commissioner for Operations, Office of Public Service and Operations Support, and Deputy Commissioner for Systems, and Applications and Supplemental Security Income Systems. We conducted this performance audit 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 the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

Appendix B – MONITORING REVIEWS

The *Social Security Protection Act of 2004* requires that the Social Security Administration (SSA) periodically review volume payees (organizational payees that serve 50 or more beneficiaries or individuals who serve 15 or more beneficiaries) and fee-for-service (FFS) payees (State/local government agencies or a community-based, nonprofit social service agency that collect a fee for providing payee services).[1] SSA conducts these reviews every 3 or 4 years.

In addition, SSA conducts discretionary reviews, such as the special site review and quick response check. SSA conducts special site reviews of organizational payees that serve 49 or fewer beneficiaries and have a higher likelihood of potential misuse. Further, the Agency conducts quick response check reviews for misuse allegations and other trigger events. SSA's monitoring reviews focus on organizational payees' compliance with managing, recordkeeping, and reporting of beneficiary benefits to ensure all funds are accounted for and beneficiary needs are met. Organizational payees that are nursing homes may be subject to mandatory or discretionary reviews depending on the number of beneficiaries served and/or whether SSA becomes aware of misuse allegations, or other adverse events.

Table B–1: Types of Representative Payee Monitoring Reviews

Type	Description	Mandate
Site	• Every volume payee at least once every 4 years • FFS payees at least once every 3 years • The reviews are scheduled *(volume payees are organizational payees serving 50 or more beneficiaries and payees classified as individual/other serving 15 or more beneficiaries)*	Congress
Special Site Review/Predictive Model	• Organizational payees serving fewer than 50 beneficiaries • Individual payees serving fewer than 15 beneficiaries • The reviews are scheduled	SSA Initiative
Quick Response Check	• All payees as needed to address allegations and trigger events • These reviews are unscheduled	SSA Initiative
Educational Visit	• New FFS payees after 6 months of authorization to collect fees • Optional for any other payee for other purposes • The reviews are scheduled	SSA Initiative

[1] *Social Security Protection Act of 2004*, Pub. L. No. 108-203 § 102 (2004). The mandatory on-site review provisions were incorporated into sections 205(j)(6) and 1631(a)(2)(G) of the *Social Security Act*, 42 U.S.C. §§ 405(j)(6) and 1383(a)(2)(G).

Appendix C – Scope and Severity of Deficiencies

Nursing homes are required to comply with Federal quality standards to receive payment under the Medicare and Medicaid programs.[1] When State inspectors determine a Medicare/ Medicaid-certified nursing home has not complied with Federal regulatory quality standards, they assess the scope and severity of the deficiency. The scope and severity rating determines the seriousness of the deficiency. The scope of the deficiency reflects the pervasiveness of the deficiency throughout the nursing home. The severity is whether an individual suffered injury, harm, impairment, or death. The State inspectors assign an alphabetical scope and severity value, A through L, to the deficiency. "A" is the least serious and "L" is the most serious rating. According to Federal regulations,[2] a nursing home that is assessed one or more deficiencies rated F and/or H through L that relate to certain Federal regulatory standards will be found to have provided substandard quality of care.

Table C–1: Scope and Severity of Deficiencies

Severity of Deficiency	Scope		
	Isolated[1]	Pattern[2]	Widespread[3]
Immediate jeopardy to resident health or safety	J	K	L
Actual harm that is not immediate jeopardy	G	H	I
No actual harm with potential for more than minimal harm that is not immediate jeopardy	D	E	F
No actual harm with potential for minimal harm (substantial compliance)	A	B	C

Note 1: Isolated is when one or a very limited number of residents or employees and/or a very limited area or number of locations within a nursing home are affected.

Note 2: Pattern is when more than a very limited number of residents or employees are affected, and/or the situation has occurred in more than a limited number of locations that are not dispersed throughout the facility.

Note 3: Widespread is when the problems causing the deficiency are pervasive throughout the facility and represent a systemic failure that affected, or has the potential to affect, a large portion or all residents or employees.

[1] *Social Security Act* §§ 1819 and 1919. 42 C.F.R. part 483, subpart B (1989).

[2] 42 C.F.R. § 488.301 (2011).

Appendix D– Social Security Administration Suitability Factors and Centers for Medicare and Medicaid Services Federal Regulatory Standards and Other Data

The Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS) makes available to the public online the Nursing Home Compare (NHC) database and Special Focus Facility (SFF) Initiative reports[1] that include information for nursing homes that are Medicare and Medicaid certified. The NHC includes the results of the last three annual inspections conducted on nursing homes by State inspectors. Further, the report identifies the Federal regulatory standards used to assess the quality of care at these facilities. We reviewed the 182 Federal regulatory standards[2] required[3] for Medicare/Medicaid certified nursing homes to determine whether they related to the Social Security Administration's (SSA) suitability factors for organizational payees.[4] As shown in the chart below, we found the CMS Federal regulatory standards and other data related to 11 of SSA's 15 suitability factors. This is not an all-inclusive list because there could be other Federal regulatory standards that relate to SSA's suitability factors. We identified those standards that appeared to directly relate to the suitability factors.

[1] HHS, CMS, *Nursing Home Compare*, medicare.gov (last visited June 29, 2017). HHS, CMS, *Special Focus Facility Initiative Report*, medicare.gov (last visited June 29, 2017).

[2] 42 C.F.R § 483.10 through 42 C.F.R §483.75.

[3] *Social Security Act* §§ 1819 and 1919. 42 C.F.R. part 483, subpart B (1989).

[4] SSA, POMS, GN-General, ch. GN 005, subch. GN 00502.130, sec. B.1 and B.3 (January 31, 2006). SSA, POMS, GN-General, ch. GN 005, subch. GN 00502.132, sec. A (October 31, 2017).

Table D–1: Comparison of SSA Suitability Factors and CMS Federal Regulatory Standards and Nursing Home Data

Count	SSA Suitability Factors	Regulatory Standards	CMS Data
1	Does the applicant demonstrate effective internal communication?	• Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. • Tell the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. • Notify the resident and the resident's representative in writing and in a language, they understand of transfer or discharge and the reasons for the move. • Upon the death of a resident, convey the resident's personal funds and an accounting of those funds to the appropriate party.	
2	Does the applicant demonstrate sound financial management policies?		• Fines and payment denials information included in CMS' NHC database
3	Does the applicant have adequate staff and resources to serve its clients?	• Have enough nurses to care for every resident in a way that maximizes the resident's well-being. • Make sure that a facility is administered in an acceptable way that maintains the well-being of each resident. • Employ staff who are licensed, certified, or registered in accordance with state laws. • Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service.	
4	Does the applicant have a stable presence in the community?	• Operate and provide services according to Federal, State, and local laws and professional standards. • A facility must be licensed under applicable State and local law.	• Placement on SFF report
5	Does the applicant hold funds in protected accounts?	• Provide proof that residents' personal money that is deposited with the nursing home is secure. • Properly hold, secure, and manage each resident's personal money, which is deposited with the nursing home.	

Count	SSA Suitability Factors	Regulatory Standards	CMS Data
6	Has adequate recordkeeping systems to ensure that the client's needs are met and benefits are properly administered?	• Let residents choose whether to manage their own money or deposit it with the nursing home. • Keep residents' personal and medical records private and confidential. • Provide written records when a resident is transferred or discharged.	
7	Does the applicant show concern for the beneficiary's well-being?	• Protect each resident from all abuse, physical punishment, and involuntary separation from others. • Protect each resident from mistreatment, neglect, and misappropriation of personal property. • Give residents proper treatment to prevent new bed (pressure) sores or heal existing bedsores. • Ensure that a nursing home area is free from accident hazards and provide adequate supervision to prevent avoidable accidents.	
8	Is the applicant knowledgeable about the beneficiary's current and foreseeable needs?	• Conduct initial and periodic assessments of each resident's functional capacity. • Assist those residents who need help with eating/drinking, grooming, and personal and oral hygiene.	
9	Does the applicant seem able to exercise good judgment and appear to have the beneficiary's best interests at heart?	• The facility must act as a fiduciary and hold, safeguard, manage, and account for the personal funds of residents that are voluntarily deposited with the facility.	
10	All known information about the applicant's past payee performance (if any)		• Placement on SFF report • Three-year inspection reports included in CMS NHC database.
11	Criminal History	• Hire only people with no legal history of abusing, neglecting, or mistreating residents or report and investigate any acts or reports of abuse, neglect, or mistreatment of residents.	

Appendix E – Sources for Suitability Factors for Organizational Payees

According to Social Security Administration (SSA) regulations, the Agency considers and weighs 15 factors when it determines the suitability of payee applicants and existing organizational payees.[1] To evaluate these factors, SSA uses several sources to include the payee application,[2] interview, and electronic Representative Payee System (eRPS). Additionally, the Agency uses the monitoring questionnaire[3] when it assesses continued suitability of an existing organizational payee.

Table E–1: Sources Used for Suitability Determination

Factor	Suitability Factor	SSA Source
1	Does the applicant demonstrate effective internal communication?	Monitoring Questionnaire
2	Does the applicant demonstrate sound financial management policies?	Monitoring Questionnaire
3	Does the applicant have adequate staff and resources to serve its clients?	Monitoring Questionnaire
4	Does the applicant have a stable presence in the community?	Payee Interview/eRPS
5	Does the applicant hold funds in protected accounts?	Payee Interview/eRPS
6	Has adequate recordkeeping systems to ensure that the client's needs are met and benefits are properly administered?	Payee Interview/eRPS
7	Voluntary Direct Deposit	Payee Interview/eRPS
8	Does the applicant show concern for the beneficiary's well-being?	Payee Interview
9	Is the applicant knowledgeable about the beneficiary's current and foreseeable needs?	Payee Interview/eRPS
10	Does the applicant seem able to exercise good judgment and appear to have the beneficiary's best interests at heart?	Payee Interview
11	Payee has custody of beneficiary.	Payee Application/ Interview
12	What is the applicant/beneficiary financial relationship (creditor)?	Payee Application/Interview
13	History of misuse of benefits	Payee Application/ Interview/eRPS
14	Past payee performance	Payee Interview/eRPS
15	Does the applicant have a criminal history?[1]	Payee Interview/eRPS

Note 1: Felony Conviction/Criminal History relates to employees of organizational payees; however, misuse is applicable to organizations.

[1] SSA, POMS, GN-General, ch. GN 005, subch. GN 00502.130, sec. B.3 (January 31, 2006). SSA, POMS, GN-General, ch. GN 005, subch. GN 00502.132, sec. A (October 31, 2017).

[2] SSA, POMS, GN ch. GN 005, subch. GN 00502.107 (June 21, 2017).

[3] Form SSA-637, *Expanded Monitoring Program Site Review Questionnaire for Volume and Fee for Service Payees* (12-2016).

Appendix F – Organizational Payee Deficiencies

From Calendar Years 2012 to 2016, the Department of Health and Human Services' Centers for Medicare and Medicaid Services assessed the 38 sample organizational payees 1,675 deficiencies for failure to comply with Federal requirements related to health and safety when providing services to residents in their care. In Table F–1, for each organizational payee, we identify the number of deficiencies by the scope and severity rating. The scope of the deficiency reflects the pervasiveness of the deficiency throughout the nursing home. The severity is whether an individual suffered injury, harm, impairment, or death.

Table F–1: CMS Deficiencies for Organizational Payees

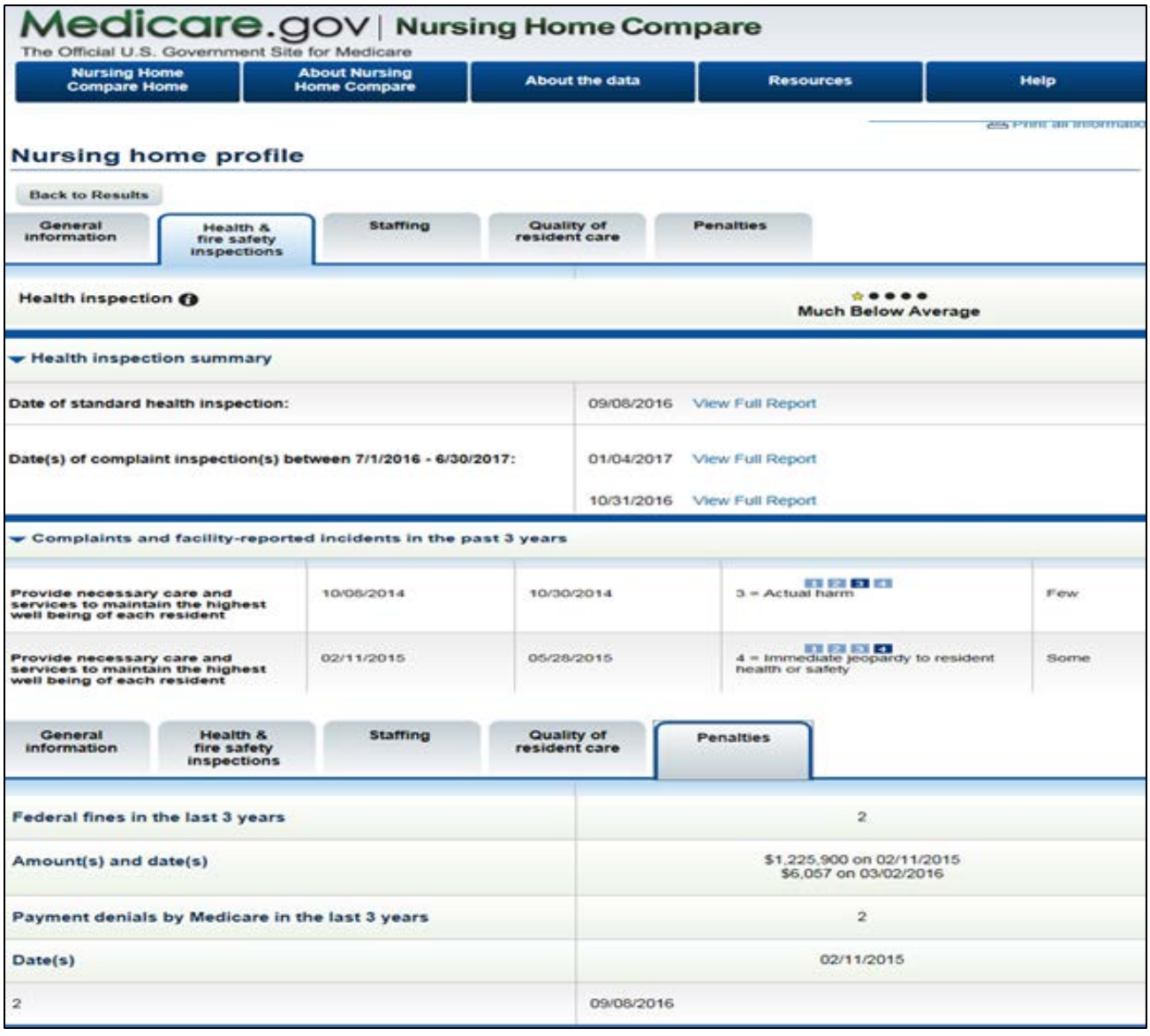
Payee	State	Sample Population	SSA Status	No Actual Harm w/ Potential for Minimal Harm (ABC)	No Actual Harm w/ Potential for More than Minimal Harm (DEF)	Actual Harm that is not Immediate Jeopardy (GHI)	Immediate Jeopardy to Residents Health or Safety (JKL)	Total Deficiencies
1	Alabama	SFF-Terminated	Inactive	1	19		11	31
2	Iowa	SFF-Terminated	Inactive	6	55	3		64
3	Iowa	SFF-Terminated	Inactive	1	46	1	4	52
4	Ohio	SFF-Terminated	Inactive	8	47	2	8	65
5	Ohio	SFF-Terminated	Active	1	52	3	1	57
6	Alabama	SFF-Unimproved	Active	3	17	1		21
7	California	SFF-Unimproved	Active	1	97	3		101
8	Florida	SFF-Unimproved	Active		10		5	15
9	Georgia	SFF-Unimproved	Active	1	18		18	37
10	Hawaii	SFF-Unimproved	Active	5	31	1		37
11	Idaho	SFF-Unimproved	Active		27	1		28
12	Illinois	SFF-Unimproved	Active	4	32	3	4	43
13	Indiana	SFF-Unimproved	Active		61	1	2	64
14	Indiana	SFF-Unimproved	Active	1	56	10	1	68
15	Kansas	SFF-Unimproved	Active	2	79	10	4	95
16	Louisiana	SFF-Unimproved	Active		21	2	9	32
17	Maine	SFF-Unimproved	Active	2	31	3		36
18	Missouri	SFF-Unimproved	Active	3	34		2	39
19	Montana	SFF-Unimproved	Active		26	1	1	28
20	Nevada	SFF-Unimproved	Active		41	7	1	49
21	New Hampshire	SFF-Unimproved	Active		27	3		30
22	North Carolina	SFF-Unimproved	Active	2	33	4	5	44
23	Oklahoma	SFF-Unimproved	Active	2	56	2	3	63
24	Pennsylvania	SFF-Unimproved	Active	1	66	4		71

Payee	State	Sample Population	SSA Status	No Actual Harm w/ Potential for Minimal Harm (ABC)	No Actual Harm w/ Potential for More than Minimal Harm (DEF)	Actual Harm that is not Immediate Jeopardy (GHI)	Immediate Jeopardy to Residents Health or Safety (JKL)	Total Deficiencies
25	Tennessee	SFF-Unimproved	Active		22		7	29
26	Texas	SFF-Unimproved	Active		9	2	7	18
27	Texas	SFF-Unimproved	Active		45	3	14	62
28	West Virginia	SFF-Unimproved	Active	1	41	1		43
29	Kentucky	Top 10 Fined	Inactive	3	24		8	35
30	Tennessee	Top 10 Fined-Terminated	Active		34	9	14	57
31	Kentucky	Top 10 Fined	Active		13		11	24
32	Kentucky	Top 10 Fined	Active		35		8	43
33	North Carolina	Top 10 Fined	Active	1	10	1	3	15
34	North Carolina	Top 10 Fined	Active	2	12		8	22
35	Pennsylvania	Top 10 Fined	Active		43	2		45
36	Tennessee	Top 10 Fined	Active		18		8	26
37	Tennessee	Top 10 Fined	Active		16		20	36
38	Virginia	Top 10 Fined	Active	1	46	2	1	50
Total				**52**	**1,350**	**85**	**188**	**1,675**

Appendix G – Excerpt of Nursing Home Compare Report for Nursing Homes

The Nursing Home Compare (NHC) Website has detailed information about every Medicare and Medicaid-certified nursing home in the country. It provides a means of researching and comparing the quality ratings of nursing homes. Individuals can search for local facilities and view their ratings based on health inspection, staffing, and quality measures that reflect the general well-being of residents. Below is an excerpt from the NHC Website, which shows a nursing home's health and fire safety inspections.

Table G–1: Excerpt from NHC website



Medicare.gov | Nursing Home Compare

The Official U.S. Government Site for Medicare

Nursing Home Compare Home | About Nursing Home Compare | About the data | Resources | Help

Nursing home profile

Back to Results

General information | Health & fire safety inspections | Staffing | Quality of resident care | Penalties

Health inspection — Much Below Average

Health inspection summary

Date of standard health inspection:	09/08/2016	View Full Report
Date(s) of complaint inspection(s) between 7/1/2016 - 6/30/2017:	01/04/2017	View Full Report
	10/31/2016	View Full Report

Complaints and facility-reported incidents in the past 3 years

Provide necessary care and services to maintain the highest well being of each resident	10/06/2014	10/30/2014	3 = Actual harm	Few
Provide necessary care and services to maintain the highest well being of each resident	02/11/2015	05/28/2015	4 = Immediate jeopardy to resident health or safety	Some

General information | Health & fire safety inspections | Staffing | Quality of resident care | Penalties

Federal fines in the last 3 years	2
Amount(s) and date(s)	$1,225,900 on 02/11/2015 $6,057 on 03/02/2016
Payment denials by Medicare in the last 3 years	2
Date(s)	02/11/2015
2	09/08/2016

Appendix H– AGENCY COMMENTS

SOCIAL SECURITY

MEMORANDUM

Date: March 9, 2018 Refer To: S1J-3

To: Gale S. Stone
Acting Inspector General

Stephanie Hall

From: Stephanie Hall
Acting Deputy Chief of Staff

Subject: Office of the Inspector General Draft Report, "Using Nursing Home Data to Determine Suitability of Representative Payees" (A-03-16-50056) -- INFORMATION

Thank you for the opportunity to review the draft report. Please see our attached comments.

Please let me know if we can be of further assistance. You may direct staff inquiries to Gary S. Hatcher at (410) 965-0680.

Attachment

COMMENTS ON THE OFFICE OF THE INSPECTOR GENERAL (OIG) DRAFT REPORT, "USING NURSING HOME DATA TO DETERMINE SUITABILITY OF REPRESENTATIVE PAYEES" (A-03-16-50056)

General Comment

Our representative payee program serves more than eight million beneficiaries/recipients. We consider many factors when we evaluate the suitability of an organizational representative payee. In addition, we have an organizational representative payee-monitoring program to assist us in determining whether organizational representative payees are properly managing the funds they receive on behalf of beneficiaries/recipients. We are committed to strengthening our processes for determining the suitability of an organizational representative payee who will best serve the interest of the beneficiary/recipient. We will continue our efforts to enhance our monitoring program to increase the number of reviews and introduce different types of representative payees, which will strengthen our level of program oversight.

Recommendation

Review and analyze the Centers for Medicare and Medicaid Service's nursing home data to determine whether it can be a tool to assess the suitability of organizational payees that are nursing homes to ensure they are serving beneficiaries' best interests, especially those organizational payees that might not meet SSA's monitoring criteria.

Response

We agree.

Mission

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