DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

MAR 15 2016

The Honorable Charles E. Grassley
Chairman, Committee on the Judiciary
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

I am writing in response to your letter of February 9, 2016, referencing your ongoing interest in the quality of care for and safety of elderly people in nursing facilities, as well as in the work of the Office of Inspector General (OIG) in preventing elder abuse. OIG's mission includes protecting the health and welfare of all program beneficiaries, and we are committed to ensuring the protection of the elderly in nursing facilities and other health care settings.

As stated in your letter, the OIG has a significant oversight role with respect to the quality of care rendered in nursing homes, especially as it relates to Medicare and Medicaid beneficiaries. OIG has conducted substantial audit and evaluation work related to these important issues and numerous investigations and enforcement actions focused specifically on nursing homes, long-term care, elder abuse, and quality of care. Additionally, OIG has consistently identified quality of care in nursing homes as part of our Top Management and Performance Challenges (TMC) for the Department and have included these issues in our annual assessment of the Department's progress addressing challenges and vulnerabilities.

OIG is conducting or currently developing several audits and evaluations focused on quality of care related to nursing homes and the elderly. Additionally, OIG is committed to continuing investigations and enforcement actions regarding substandard quality of care for elderly patients, ensuring compliance, and providing guidance to the health care profession and the nursing facility industry.

We work closely with the Centers for Medicare & Medicaid Services (CMS) and with law enforcement partners at the Department of Justice (DOJ) and through the Federal Elder Justice Interagency Working Group to promote better care for elderly persons and to prosecute providers that subject them to abuse or neglect. Additionally, State Medicaid Fraud Control Units (MFCUs), which receive certification, oversight, technical assistance, and training from OIG, devote substantial resources and have a core responsibility to investigate and prosecute patient abuse and neglect in both Medicaid-funded facilities and board and care facilities.

We share your concerns regarding the disturbing reports of health care workers abusing the elderly and compounding that abuse by spreading images on social media, and we continue to work with our State partners to address elder abuse issues. We have alerted the 50 MFCUs about the ProPublica articles and have requested that they be increasingly aware of and appropriately investigate abuse allegations in health care facilities involving the inappropriate use of social media.

In your letter you asked us to respond to six questions; responses to those questions are included in the enclosure. We have limited our responses regarding audits and evaluations to quality of care and elder abuse issues in nursing homes rather than financial and reimbursement issues.

My staff will contact your staff to schedule a briefing to discuss the work and activities referenced in our response. Additionally, we are currently updating our Work Plan and would welcome your input during this process, particularly on the important issue of ensuring the protection of the elderly as raised by your letter. If you have any questions, please contact me, or your staff may contact Christopher Seagle, Director of External Affairs, at 202-260-7006 or Christopher.Seagle@oig.hhs.gov.

Sincerely,

Daniel R. Levinson

Daniel R. Levinson
Inspector General

Enclosures:
Answers to the Six Questions
Appendix — Summary of ongoing and completed audits, evaluations, and investigations and State-by-State tables

Answers to the Six Questions asked of Daniel R. Levinson by Senator Grassley

Question 1: In the past five years, how many nursing home abuse investigations and audits has HHS OIG conducted? Please provide a list of all investigations and audits.

Answer: Given our statutory authorities, the OIG conducts a number of discrete activities to oversee the programs of the Department and carry out our mission. These include: investigations to support criminal, civil, and administrative actions; audits and evaluations; and oversight and grant approval for MFCUs. For each of these categories, we provide information related to OIG work involving nursing homes, long-term care, elder abuse, and quality of care over the last 5 years. For a detailed summary of this work, from 2011 to the present, please see the appendix.

Number of Audits, Evaluations, and Investigations related to nursing homes, long-term care, elder abuse, and quality of care from 2011 to 2015	
Investigations	41
Audits and Evaluations	17
OIG involvement with False Claims Act settlements	19

Investigations and False Claims Act Cases

OIG closed 41 cases from 2011 to 2015 relating to patient abuse and neglect in skilled nursing facilities (SNFs), assisted living facilities, and adult homes. Cases closed in a particular calendar year may have been opened in a previous year, and action (e.g., settlement, prosecution, etc.) may not have been taken in all closed cases. Please see the answer to question #2 for information regarding closed cases with enforcement action.

OIG also works with the MFCUs to identify not only patient abuse cases but all Medicaid fraud cases that violate State law. The MFCUs play a unique role in investigating and prosecuting patient abuse or neglect. As part of their Federal grant, MFCUs are required to investigate complaints of patient abuse or neglect in Medicaid-funded facilities and board and care facilities. MFCUs also must prosecute patient abuse and neglect cases under State law or refer them to other prosecutors. For more information on MFCUs, please see OIG's answer to question #6. Additionally, we continue to work with State professional boards to issue exclusions for revocation or suspension of health care licenses.

Generally, OIG works with the DOJ on health care False Claims Act (FCA) cases. FCA cases can include allegations related to quality of care, including allegations of billing for grossly substandard care or medically unnecessary and unreasonable rehabilitation therapy in nursing homes. When an FCA settlement resolves allegations of fraud that impact the quality of patient

care, OIG may require the provider to enter into a "quality-of-care" Corporate Integrity Agreement (CIA). The terms of each CIA are negotiated between OIG and the provider and the resulting agreement is individually tailored to ensure the provider operates in compliance with relevant laws going forward. Under many CIAs, the provider must retain an independent quality monitor to look at the provider's delivery of care and evaluate its ability to prevent, detect, and respond to patient care problems. When the settlement involves allegations of medically unnecessary and unreasonable or potentially harmful rehabilitation therapy, OIG may require the provider to enter into a CIA that requires the provider to retain an Independent Review Organization to review its Part A claims and its oversight of rehabilitation therapy. Please see the appendix for a list of all FCA cases and related CIAs.

Selected Case Summaries

- Extendicare Health Services: In the largest failure-of-care FCA settlement with a nationwide skilled nursing facility chain, Extendicare Health Services, Inc. (Extendicare), and its subsidiary, Progressive Step Corporation (ProStep), agreed to pay $38 million to resolve allegations that Extendicare billed Medicare and Medicaid for materially substandard and/or worthless skilled nursing services and billed Medicare for medically unreasonable and unnecessary rehabilitation therapy services. Extendicare allegedly provided inadequate care to residents at some of its facilities and, as a result, patients suffered fractures, head injuries, malnutrition, dehydration, pressure ulcers, infections, and amputation of limbs. Extendicare and Prostep also agreed to enter into a 5-year CIA that required them to, among other things, retain a quality monitor to evaluate their quality assessment and improvement systems and oversight of rehabilitation therapy.

- Country Villa: Country Villa Service Corp, d/b/a Country Villa Health Services, and the ARBA Group, Inc., CF Watsonville East, LLC, and CF Watsonville West, LLC entered into a separate FCA settlement agreement worth a combined $3.8 million to resolve allegations of false claims for materially substandard or worthless services. The United States alleged that employees at Country Villa Watsonville East Nursing Center and Country Villa Watsonville West Nursing Center persistently overmedicated elderly and vulnerable residents of their facilities, causing infection, sepsis, malnutrition, dehydration, falls, fractures, pressure ulcers, and, for some beneficiaries, premature death. In addition to the settlements, the CF Watsonville companies entered into a 5-year CIA under which they will retain a quality monitor to perform quarterly reviews of the facilities' quality and compliance systems.

- Foundation Health Services: Foundation Health Services, Inc.; Richard T. Daspit, Sr.; and the following entities: Rock Glen Healthcare, Inc.; American Family Services, Inc.; Huntingdon Nursing Center, Inc.; Bluebonnet Healthcare, Inc.; Magnolia Healthcare, Inc.; and Ravenwood Healthcare, Inc. (collectively "Foundation") agreed to pay $750,000 to settle allegations that Foundation violated the FCA by submitting or causing to be submitted false claims for materially substandard and/or worthless skilled nursing services that resulted in falls, fractures, head injuries, malnutrition, dehydration, pressure sores, and infections. Foundation entered into a 5-year CIA under which it will retain a

quality monitor to perform quarterly reviews of the facilities' quality and compliance systems.

Audits and Evaluations

The OIG conducts both audits and evaluations to oversee the operations of the Department of Health and Human Services (HHS). Audits and evaluations examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities. These reviews help reduce fraud, waste, abuse, and mismanagement and promote economy and efficiency throughout HHS. Audits and evaluations present practical recommendations for improving program operations and in many cases address quality-of-care issues.

During the past 5 years, OIG has completed 17 audits and evaluations examining elder abuse and quality of care in nursing homes and other long-term care settings. Please see the appendix for summaries of these studies. For the purposes of this response, we have not included reviews of nursing homes that specifically address reimbursement and payment issues.

In February 2014 OIG released an evaluation examining adverse events in SNFs. We found that an estimated 22 percent of Medicare beneficiaries experienced adverse events during SNF stays, and an additional 11 percent experienced temporary harm events.[1] Physician reviewers determined that 59 percent of the adverse events and temporary harm events were clearly or likely preventable. Resulting hospital care associated with these events cost Medicare an estimated $2.8 billion in 2001. We made several recommendations to the Agency for Healthcare Research and Quality (AHRQ) and CMS, as those agencies share responsibility in addressing the issue; both AHRQ and CMS concurred with our recommendations.

In summary, we have covered several important issues in our work on elder abuse in nursing homes and provided CMS with recommendations for improvement. We reviewed nursing homes' compliance with Federal requirements for reporting allegations of abuse or neglect and the use of criminal background checks that screen long-term-care employees. We have been instrumental in bringing attention to the use of antipsychotic drugs in nursing facilities, which has led to reforms and more appropriate prescribing of these drugs. Several OIG reports have addressed nursing home deficiencies and verification and correction of those deficiencies by State oversight agencies that conduct survey and certification reviews on behalf of Medicare and Medicaid.

[1] An adverse event is defined as harm to a patient or resident as a result of medical care or in a health care setting. For purposes of calculating an incidence rate for our report, we defined "adverse events" as events that resulted in one of the four most serious categories on our modified version of the NCC MERP Patient Harm Index (classified in the index on F-I): prolonged SNF stay or hospitalizations (including emergency room visit), permanent harm, life-sustaining intervention, or death

Question 2: Please provide the number of nursing home abuse investigations by HHS OIG in the past five years that resulted in criminal and civil referrals to the Department of Justice. Of those, how many have resulted in prosecution? Please list referrals by state.

Answer: OIG works together with its MFCU partners on many nursing home abuse and neglect cases. As such, all cases with enforcement action were "referred" (presented) to local U.S. Attorney's Offices, State Prosecutors, or both. Presenting a case to a prosecutor does not necessarily indicate that the case will be accepted for prosecution. However, of cases accepted for prosecution, OIG had a total of 18 criminal actions, 7 civil actions, and monetary receivables of $6,206,350 from CY 2010 to 2015. Please see the appendix for a table, by Judicial District, of cases accepted for prosecution. All cases included in these figures are completed criminal or civil action and were worked by OIG containing an allegation code of patient abuse and neglect in SNFs, assisted living facilities, and adult homes.

Cases Accepted for Prosecution CY 2010–2015	
Criminal Actions	18
Civil Actions	7
Monetary Receivables	$6,206,350

Question 3: Please provide the number of nursing home audits HHS OIG performed in the past five years that resulted in criminal or civil referral to the Department of Justice. Of those, how many resulted in prosecution? Please list audits by state.

Answer: In the past 5 years, none of OIG's audits or evaluations has directly resulted in formal referrals to the DOJ or resulted in prosecutions. This is not unusual because auditors and evaluators primarily make internal referrals of findings of potential civil or criminal concern to OIG's investigators for further review and potential presentation to DOJ. Although audits and evaluations do not typically result in criminal or civil referrals to DOJ, OIG has numerous tools at its disposal to address elder abuse and quality-of-care issues in nursing homes, including opening investigative cases.

We also maintain a strong dialogue with the DOJ – both on the criminal and civil side, chiefly through our legal staff and our investigators. If for example an audit of a particular provider indicated substantial potential fraud, we would discuss with DOJ and determine whether or not the provider should be referred for investigation.

Additionally, OIG and DOJ staff frequently dialogue when final evaluations and audit reports are issued. For example, OIG reviews of changes in billing patterns of SNFs resulted in exchanges between DOJ's staff and our staff regarding sharing facility-specific billing data to identify outliers that may suggest fraudulent billings.

A similar dialogue also exists with our State partners, notably with respect to the MFCU. Many cases are worked jointly with our investigators, and many "global" cases involve multiple law enforcement partners.

Finally, our audit and evaluation staff collaborate closely with our investigators and, when warranted, may follow up on issues identified by an investigator. For instance, several investigators may have a widespread concern about a particular aspect of nursing homes' quality of care that could be examined in a national review conducted by our evaluation staff. Our investigators, auditors, and evaluators are in constant communication to determine the best course of action and to share information. Additionally, ongoing audits can (and do) result in referrals to our legal staff for possible use of OIG administrative sanctions such as civil monetary penalties or exclusions.

Question 4: Medicare-certified and Medicare-Medicaid dually certified nursing homes are required to follow CMS's State Operations Manual which provide the procedural guidelines by which nursing home complaints are made and processed. According to HHS OIG's archive, the last review of the State's complaint process was in 2006. Does HHS OIG plan an updated review?

Answer: In 2014 OIG issued work that both updates and builds on our 2006 report. OIG's August 2014 report *Nursing Facilities' Compliance with Federal Requirements for Reporting Allegations of Abuse or Neglect* describes States' compliance with the updated reporting requirements for abuse and neglect – that is, allegations of abuse or neglect must be reported to the facility administrator or designee and the State survey agency within 24 hours, and the results of investigations of these allegations must be reported to the same authorities within 5 working days. The 2014 report found that 24 percent of nursing facilities did not maintain policies that address Federal regulations for reporting either allegations of abuse or neglect and investigation results. Further, 39 percent of nursing facilities did not have documentation supporting the facilities' compliance with Federal regulations under section 1150B of the Social Security Act. Lastly, only 47 percent of allegations of abuse or neglect and the subsequent investigation results was reported as required by Federal law.

At this time, we do not currently have plans to conduct another review of these issues.

Question 5: Does HHS OIG have a plan in place to detect and combat the apparent growing number of instances of elder abuse? If so, what is the plan? If not, why not?

Answer: The health and welfare of program beneficiaries is at the core of OIG's mission. To accomplish that mission, we have prioritized work that fosters a high quality of care within all Departmental programs and promotes public safety as explained in our 2014-2018 Strategic Plan. OIG's particular areas of focus on which it has prioritized work are quality-of-care issues in nursing homes, hospice, and home-and-community-based care (HCBS). Throughout OIG's Work Plan you will find important planned and ongoing work that focuses on these issues. Our

FY17 budget justification also explains how OIG will use resources to provide critical oversight on issues related to patient safety and quality of care in several areas, including nursing homes. While the development of this oversight work is a continual process, OIG currently releases its planned work twice a year. The most recent update to the OIG Work Plan in November 2015 describes the following audits and evaluations that OIG plans to begin or are underway:

- assessing State oversight of nursing homes by reviewing whether correction of deficiencies identified during recertification reviews are verified by the State survey agency, similar to some of the reports above;
- continuing work involving background checks for long-term-care employees in 10 different types of health care settings;
- determining the incidence of adverse events in inpatient rehabilitation facilities and long-term-care hospitals;
- examining concerns about poor quality of care at group homes including reporting of incidents of abuse and neglect and expanding this work to include nursing homes; and,
- reviewing potentially avoidable hospitalizations for urinary tract infections in nursing homes.

In addition to planned audits and evaluations, OIG continues to pursue enforcement actions against nursing homes that render substandard care. By actively participating in the Federal Elder Justice Interagency Working Group, OIG is ensuring we have strong relationships with agency and law enforcement partners to ensure we are prepared for future investigations and prosecutions related to quality of care and abuse or neglect of the elderly.

We also continuously engage with internal and external stakeholders to enhance the relevance and impact of our work to combat health care fraud, including instances of elder abuse, as demonstrated by our leadership in the Healthcare Fraud Prevention Partnership, our association with the National Health Care Anti-Fraud Association, and our support to the Senior Medicare Patrol. In addition, we work closely with our local and State partners (specifically the MFCUs) who have primary jurisdiction in the area of abuse and neglect.

OIG has also consistently identified quality of care in nursing homes as part of our Top Management and Performance Challenges (TMC) for the Department. Our prior work has identified a number of issues and recommendations that we believe will help the Department address this challenge. As Americans continue to live longer and with more chronic medical conditions, the Department must ensure that beneficiaries receive high-quality nursing home, hospice, and HCBS, including personal care services. Challenges persist with fraud, waste, and abuse with nursing home and hospice care and HCBS. OIG believes more should be done to prioritize quality care for this community to improve internal controls and offer better guidance and training for surveyors to ensure that nursing homes with recorded quality and safety issues correct their deficiencies. By continuing to identify elder abuse and quality of care as a TMC, OIG can over time highlight these issues for the Department while we continue to apply all the tools at our disposal to address the problems we have identified.

6. Is HHS OIG interfacing with states to ensure that elder abuse is reported, investigated, and prosecuted? If not, why? If so, what resources does it have at its disposal?

The MFCUs are the State partners with which OIG works to ensure that elder abuse is reported, investigated, and prosecuted. As previously mentioned, OIG's investigators may work with MFCUs on a particular patient abuse or neglect case. Additionally, through OIG's role in overseeing and administering the MFCU's Federal grant, OIG ensures that MFCUs meet the Federal requirement to investigate and prosecute patient abuse or neglect cases. The MFCUs must investigate abuse or neglect that occurs in Medicaid-funded facilities or board and care facilities (i.e., assisted living facilities) regardless of funding. Due to this authority, MFCU investigations of patient abuse or neglect are not limited to seniors. These investigations may involve a wide range of patients, and the information and statistics presented below and in the appendix are for all patient types.

By way of background, OIG has oversight authority of the MFCUs, which operate in 49 States and the District of Columbia. The OIG annually recertifies each MFCU, assesses each MFCU's performance and compliance with Federal requirements, and administers a Federal grant award to fund a portion of each MFCU's operational costs. OIG also publishes periodic reports on each State's Unit as well as performance statistics. MFCU performance standards expect MFCUs to maintain adequate referrals, including for patient abuse or neglect, and that a Unit's case mix include a balance of fraud and patient abuse or neglect cases.

Cases of patient abuse and neglect investigated by the MFCUs include aggravated assaults, injury to elderly or disabled persons, and theft of patient funds. In a recent case reported by the Florida MFCU, for instance, the MFCU investigated an owner of an adult family care home for allegations that included neglecting residents, failing to provide medical services for a resident's wounds, willfully abusing a disabled adult, and financially exploiting residents. The owner was convicted and sentenced to more than 8 years of incarceration.

It is important to point out that the MFCU's authority to receive funding for patient abuse and neglect cases does not extend to abuse and neglect occurring in non-facility settings, such as in a beneficiary's home or transportation service. MFCUs must decline referrals alleging abuse and neglect by personal care attendants or other individuals operating in these other settings. The President's FY 2017 budget currently includes a proposal to address this limitation. See FY 2017 HHS Budget in Brief, pages 88-89.

MFCUs have achieved significant results from their patient abuse and neglect cases as shown in the chart below. The appendix contains a State-by-State chart detailing patient abuse and neglect activities and outcomes for FY 2015 at each MFCU.

	2015	2014	2013	2012	2011	2010	Total
Open Cases	3,224	3,280	3,201	3,859	4,130	3,500	-
Indictments	508	477	396	381	403	555	2,720
Convictions	456	371	352	353	409	490	2,431

We note that some Units are more or less actively involved in this type of case because of varying State laws and whether or not the Unit has original jurisdiction to investigate and/or prosecute patient abuse and neglect. For example, in some States MFCUs are the mandatory reporting agency to which providers must report any abuse and neglect. In other States, local law enforcement is the primary entity that handles abuse and neglect, and MFCUs may play an advisory and monitoring role during the case.

OIG Exclusions

OIG excludes convicted individuals from federally funded health care programs when providers are convicted of certain offenses. Specifically, section 1128(a)(2) of the Social Security Act requires that any individual or entity be excluded that has been convicted, under Federal or State law, of a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care item or service. Exclusion means that no payment will be made for any health care items or services furnished, ordered, or prescribed by an excluded individual.

For exclusions relating to patient neglect or abuse, the Office of Investigations works with the MFCUs and State licensing boards to identify cases that would be eligible for exclusion. From 2011–2015, the OIG excluded a total of 1,166 individuals and entities in this category.

The table below indicates the number of completed exclusions under the OIG's authority.

Calendar Year	Patient Abuse or Neglect Exclusions
2015	320
2014	217
2013	177
2012	227
2011	225

The OIG utilizes additional exclusions authorities that may include elements related to patient abuse or neglect, but we cannot distill out the numbers of completed actions. For example, the OIG also has the authority to exclude an individual who loses a professional health care license based on conduct related to professional performance, professional competency, or financial integrity.

In 2015, OIG excluded a total of 1,613 individuals and entities based on the loss of a professional license. Although we do not capture the specific basis for these exclusion actions, in our experience some of these exclusions included instances in which a nurse would have diverted medications meant to ease a patient's pain or a physician would overprescribe controlled substances, contributing to a patient's addiction.

Appendix 1

Question1 In the past five years, how many nursing home abuse investigations and audits has HHS OIG conducted? Please provide a list of all investigations and audits.

Summaries of audit and evaluation work examining nursing home abuse and elder abuse work 2010–2015

1. ***National Background Check Program for Long-Term Care Employees: Interim Report*** OEI-07-10-00420 (01/19/2016), http://oig.hhs.gov/oei/reports/oei-07-10-00420.pdf
   Long-term-care employees provide essential care to patients in settings such as nursing facilities, home health agencies, and hospices. Ensuring that these employees have undergone a minimum level of screening helps protect the safety of beneficiaries in these settings. The Patient Protection and Affordable Care Act (ACA) provides grants to States to implement background check programs for prospective long-term-care employees. The ACA also requires OIG to conduct an evaluation of this grant program—known as the National Background Check Program—after its completion. This interim report describes the overall implementation status and States' results from the first 4 years of the program, and provides the Centers for Medicare & Medicaid Services (CMS) with information that may assist its ongoing administration of this program. OIG also plans to issue a final evaluation of the grant program after its completion. We reviewed reports that each of the 25 States participating in the grant program submitted to CMS. We also reviewed the data that 14 States provided regarding the number of background checks completed. Four years into the grant program, the 25 States that are receiving grants reported having achieved varying levels of program implementation. Specifically, some States have not obtained legislation that would enable them to conduct background checks. Other States have not yet implemented processes to collect fingerprints and monitor criminal history information after individuals begin employment. Only 6 of the 25 States have submitted to CMS data sufficient to calculate the percentage of prospective employees who were disqualified because of their background checks. In these six States, 3 percent of prospective employees were disqualified from employment. Of the remaining 19 States, 11 were not yet submitting data reports and 8 had data gaps that prevented the calculation of disqualification rates.

2. ***Nursing Facilities' Compliance with Federal Requirements for Reporting Allegations of Abuse or Neglect*** OEI-07-13-00010 (08/15/2014), http://oig.hhs.gov/oei/reports/oei-07-13-00010.pdf
   To protect the well-being of residents, nursing facilities must comply with Federal regulations to develop and implement written policies related to reporting allegations of abuse, neglect, mistreatment, injuries of unknown source, and misappropriation of resident property (allegations of abuse or neglect). Further, allegations of abuse or neglect must be reported to the facility administrator or designee and the State survey agency within 24 hours. Results of investigations of these allegations must be reported to the same authorities within 5 working days. Nursing facilities must also notify owners, operators, employees, managers, agents, or contractors of nursing facilities (covered individuals) annually of their obligation to report reasonable suspicions of crimes. We found that 85 percent of nursing facilities reported at least one allegation of abuse or neglect to OIG in 2012. Additionally, 76 percent of nursing facilities maintained policies that address Federal regulations for reporting both allegations of abuse or neglect and investigation results. Further, 61 percent of nursing facilities had documentation supporting the facilities' compliance with both Federal regulations under section 1150B of the

Social Security Act. Lastly, 53 percent of allegations of abuse or neglect and the subsequent investigation results was reported, as required by Federal law.

3. ***Criminal Convictions for Nurse Aides with Substantiated Findings of Abuse, Neglect, and Misappropriation*** OEI-07-10-00422 (10/05/2012), http://oig.hhs.gov/oei/reports/oei-07-10-00422.pdf
   ACA mandate. In September 2011, we requested from each State's nurse aide registry a roster of all nurse aides who received a substantiated finding of abuse, neglect, and/or misappropriation of property during 2010. For each nurse aide on these rosters, we requested criminal history record information from the Federal Bureau of Investigation. We recorded convictions from each positively matched individual's criminal history. Nineteen percent of nurse aides with substantiated findings had at least one conviction in their criminal history records prior to their substantiated finding. We also determined whether nurse aides with each type of substantiated finding were more likely to have certain types of convictions. We found that nurse aides with substantiated findings of either abuse or neglect were 3.2 times more likely to have a conviction of crime against persons than nurse aides with substantiated findings of misappropriation, and nurse aides with substantiated findings of misappropriation were 1.6 times more likely to have a conviction of crime against property than nurse aides with substantiated findings of abuse or neglect.

4. ***Nursing Facility Assessments and Care Plans for Residents Receiving Atypical Antipsychotic Drugs*** OEI-07-08-00151 (07/06/2012), http://oig.hhs.gov/oei/reports/oei-07-08-00151.pdf
   Nursing facilities must meet Federal quality and safety standards to participate in the Medicare and/or Medicaid programs. The standards require extra protections for nursing facility residents receiving antipsychotic drugs. Nursing facility staff are required to assess each resident's functional capacity upon admission to the facility and periodically thereafter. Staff must specify in a written care plan, based on these assessments, the services that each resident needs. CMS contracts with State agencies to ensure that nursing facilities comply with the standards for resident assessments and care plans. Nearly all of the more than 600 records reviewed (99 percent) failed to meet one or more Federal requirements for resident assessments and/or care plans. The resident assessment and care plan process involves four steps. One-third of records reviewed did not contain evidence of compliance with Federal requirements regarding resident assessments, the first step. Further, for 4 percent of records, nursing facility staff did not document consideration of the Resident Assessment Protocol for psychotropic drug use as required, the second step. Ninety-nine percent of records did not contain evidence of compliance with Federal requirements for care plan development, the third step. Finally, 18 percent of records reviewed did not contain evidence to indicate that planned interventions for antipsychotic drug use—the fourth step—actually occurred.

5. ***Nationwide Program for National and State Background Checks for Long-Term-Care Employees—Results of Long-Term-Care Provider Administrator Survey*** OEI-07-10-00421 (01/19/2012), http://oig.hhs.gov/oei/reports/oei-07-10-00421.pdf
   ACA mandate. As of March 2011, 10 States had been awarded funding under the nationwide program: Alaska, California, Connecticut, Delaware, District of Columbia, Florida, Illinois, Missouri, New Mexico, and Rhode Island. We mailed a survey to a stratified sample of 200 long-term-care provider administrators in these States. Survey results indicate that 94 percent of

administrators conducted background checks on prospective employees. Only 4 percent of those administrators encountered individuals who were unwilling to undergo a background check. Twenty-three percent of administrators believed that their organizations' current background check procedures reduced the pool of prospective employees. Overall, 81 percent of administrators believed that there is a sufficient pool of qualified applicants for job vacancies. However, survey results indicate that 9 percent of administrators did not receive applications from qualified individuals for at least some job vacancies.

6. ***Medicare Atypical Antipsychotic Drug Claims for Elderly Nursing Home Residents*** OEI-07-08-00150 (05/04/2011), http://oig.hhs.gov/oei/reports/oei-07-08-00150.pdf
[This work was done in response to an earlier request from Senator Grassley.] Fourteen percent of the 2.1 million elderly (i.e., age 65 and older) nursing home residents had at least 1 claim for atypical antipsychotics. Our medical record review determined that 83 percent of Medicare claims for atypical antipsychotic drugs for elderly nursing home residents was associated with off-label conditions and that 88 percent was associated with the condition specified in the Food and Drug Administration (FDA) boxed warning. If during the approval process or after a drug has been approved for marketing, drug manufacturers and/or the FDA determine that the drug may produce severe or life-threatening risks, the FDA requires that drug manufacturers include a boxed warning (also referred to as a black-box warning) on the product's labeling to warn prescribers and consumers of these risks. In April 2005, the FDA issued a public health advisory for atypical antipsychotic drugs. The FDA required manufacturers of these drugs to include a boxed warning regarding the increased risk of mortality when these drugs are used for the treatment of behavioral disorders in elderly patients with dementia. We further determined through medical record review that 22 percent of the atypical antipsychotic drugs associated with the claims were not administered in compliance with CMS standards regarding unnecessary drugs in nursing homes, amounting to $63 million.

7. ***Medicaid Nursing Facilities' Employment of Individuals with Criminal Convictions*** OEI-07-09-00110 (03/01/2011), http://oig.hhs.gov/oei/reports/oei-07-09-00110.pdf
Our analysis of criminal history records maintained by the Federal Bureau of Investigation (FBI) revealed that 92 percent of nursing facilities employed at least one individual with at least one criminal conviction. Overall, 5 percent of nursing facility employees had at least one criminal conviction. Federal regulation prohibits Medicare and Medicaid nursing facilities from employing individuals found guilty of abusing, neglecting, or mistreating residents by a court of law, or who have had a finding entered into the State nurse aide registry concerning abuse, neglect, or mistreatment of residents or misappropriation of their property. Interpretive guidelines from CMS for this regulation state that "[nursing] facilities must be thorough in their investigations of the past histories of individuals they are considering hiring." Despite this guidance, Federal law does not require that nursing facilities conduct FBI or statewide criminal background checks. Although FBI-maintained criminal history records provide a comprehensive source of criminal histories, the records do not contain information on whether the victim of a crime was a nursing facility resident and therefore cannot be used by themselves to determine whether a conviction disqualifies an individual from nursing facility employment.

8. ***The Medicare Payment System for Skilled Nursing Facilities Needs To Be Re-Evaluated*** OEI-02-13-00610 (September 2015), http://www.oig.hhs.gov/oei/reports/oei-02-13-00610.pdf
OIG and other entities have raised longstanding concerns about Medicare's method of paying for therapy in the skilled nursing facility (SNF) payment system. This study provides further evidence that supports and quantifies these concerns. Medicare pays SNFs a daily rate for nursing, therapy, and other services. The daily rate for therapy is primarily based on the amount of therapy provided, regardless of the specific beneficiary characteristics or care needs. This report compared Medicare payments to SNFs' costs for therapy over a 10-year period. It also determined the extent to which changes in SNF billing affected Medicare payments from fiscal years 2011 to 2013. From 2002 to 2010, Medicare payments for therapy greatly exceeded SNFs' costs for therapy. And under the current payment system, SNFs increasingly billed for the highest level of therapy even though key beneficiary characteristics remained largely the same. Increases in SNF billing—particularly for the highest level of therapy—resulted in $1.1 billion in Medicare payments in FY 2012 and FY2013.

9. ***Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries*** OEI-06-11-00370 (February 2014), http://oig.hhs.gov/oei/reports/oei-06-11-00370.pdf
This study is one of a series of OIG reports about adverse events (patient harm) in health care facilities. The report provides a national incidence rate for adverse events in SNFs based on physician review of hundreds of nursing home medical records for post-acute Medicare stays. The physician reviewers also determined the extent to which these events were preventable and the study measured the cost to the Medicare program. SNF post-acute care is intended to help beneficiaries improve health and functioning following a hospitalization and is second only to hospital care among inpatient costs to Medicare. We found that an estimated 33 percent of Medicare beneficiaries experienced harmful events during their SNF stays, and that 59 percent of these events was preventable. The preventable harm was largely the result of substandard treatment, inadequate resident monitoring, and failure or delay of necessary care. Over half of the residents who experienced harm returned to a hospital for treatment, with an estimated cost to Medicare of $208 million in August 2011, which equates to $2.8 billion spent on hospital treatment for harm caused in SNFs in FY 2011.

10. [SEK(1)]***Medicare Nursing Home Resident Hospitalization Rates Merit Additional Monitoring*** OEI-06-11-00040 (November 2013), http://oig.hhs.gov/oei/reports/oei-06-11-00040.pdf
Another OIG study released in November 2013 found that one-quarter of Medicare nursing home residents in FY11 were transferred to hospitals for inpatient admissions at a cost of $14.3 billion. We recommended that the Agency for Healthcare Research and Quality (AHRQ) and CMS seek to reduce resident harm through methods used to promote hospital safety. In 2014 AHRQ and CMS began a collaboration to raise awareness about nursing home harm, including promoting a list of potential nursing home harm events that are not commonly associated with SNF care, to better educate SNF staff. CMS also modified its guidance to State agency surveyors regarding assessment of nursing home efforts for reducing adverse events.

11. ***Skilled Nursing Facilities Often Fail to Meet Care Planning and Discharge Planning Requirements*** OEI-02-09-00201 (February 2013), http://oig.hhs.gov/oei/reports/oei-02-09-00201.pdf
    This study is part of a larger body of work about SNF payments and quality of care. SNFs are required to develop a care plan for each beneficiary, provide services in accordance with the care plan, and plan for each beneficiary's discharge. These requirements are essential to ensuring that beneficiaries receive appropriate care and safely transition from one care setting to another. This report used a medical record review of SNF stays in 2009 to determine the extent to which SNFs developed care plans that met Medicare requirements, provided services in accordance with care plans, and planned for beneficiaries' discharges as required. For 37 percent of stays, SNFs did not develop care plans that met requirements nor provide services in accordance with care plans. For 31 percent of stays, SNFs did not meet discharge planning requirements. Medicare paid approximately $5.1 billion for stays in which SNFs did not meet these quality-of-care requirements. Additionally, reviewers found examples of poor quality care related to wound care, medication management, and therapy. These findings raise concerns about what Medicare is paying for. They also demonstrate that SNF oversight needs to be strengthened to ensure that SNFs perform appropriate care planning and discharge planning.

12. ***Oversight of Quality of Care in Medicaid Home and Community-Based Services Waiver Programs*** OEI-02-08-00170 (January 2012), http://oig.hhs.gov/oei/reports/oei-02-08-00170.pdf
    In recent years States have started providing the majority of their Medicaid-funded long-term care services in homes and other community-based settings instead of nursing homes. Most of this care is provided to disabled persons over age 65 through section 1915(c) home and community-based care (HCBS) waiver programs. States must operate their HCBS waiver programs in accordance with certain quality assurances. To meet these assurances, States must demonstrate that they have systems to effectively monitor the adequacy of service plans, the qualifications of providers, and the health and welfare of beneficiaries. But 7 of the 25 States that we reviewed did not have adequate systems to ensure the quality of care provided to beneficiaries. Although CMS renewed the waiver programs in all seven of these States, three did not adequately correct identified problems. These three States had yet to adequately address the problems after more than a year following renewal. In addition, CMS did not consistently use the few tools it has to ensure that States correct problems related to quality of care.

13. ***Medicaid Services Provided in an Adult Day Health Setting*** OEI-09-07-00500 (July 2011), http://oig.hhs.gov/oei/reports/oei-09-07-00500.pdf
    Adult day health centers are organized outpatient programs that provide health, therapeutic, and social services to program participants. Most participants are elderly and disabled. In general, adult day health services need to be ordered or requested by a physician or medical practitioner, provided to eligible beneficiaries, included in a plan of care, rendered by staff whose qualifications or supervision meet State licensing requirements, and supported by documentation. On 40 percent of service days in 2007, however, beneficiaries received no documented health services. And when beneficiaries did receive health or therapeutic services, approximately 43 percent of such therapy services was provided by staff who lacked required

supervision. This indicates the need for enforcement of current therapy supervision requirements.

14. ***Unidentified and Underreported Federal Deficiencies in California's Complaint Surveys of Nursing Homes Participating in the Medicare and Medicaid Programs*** A-09-09-00114 (September 2011), http://oig.hhs.gov/oas/reports/region9/90900114.pdf
The State Survey agency (division) did not always identify and report deficiencies for unmet Federal participation requirements when conducting complaint surveys from 2006 through 2008. For 24 complaint surveys at 3 nursing homes that we judgmentally selected, the division did not (1) identify 41 deficiencies for noncompliance with the Federal participation requirements associated with the complaint surveys that cited State requirements, (2) determine the deficiency ratings for those 41 deficiencies, and (3) enter the Federal deficiencies and deficiency ratings into the complaints and incidents tracking system.

    The division's policy and procedures for investigating complaints did not require State surveyors to cite deficiencies for all unmet Federal participation requirements. Instead, the policy and procedures permitted the State surveyors to cite violations of State requirements while not citing the associated Federal requirements. As a result, the division did not always identify Federal deficiencies, determine deficiency ratings, and report the information to CMS.

15. ***Federal Survey Requirements Not Always Met for Three California Nursing Homes Participating in the Medicare and Medicaid Programs*** A-09-11-02019 (February 2012), http://oig.hhs.gov/oas/reports/region9/91102019.pdf
From 2006 through 2008 the division did not always determine deficiency ratings, ensure the adequacy of correction plans, and verify nursing homes' correction of identified deficiencies in accordance with Federal requirements. For three nursing homes that we judgmentally selected, the division:
    - understated the deficiency ratings for 23 of 178 deficiencies (13 percent), including 9 deficiencies that involved actual harm to resident health and safety;
    - did not ensure that 40 of 52 correction plans (77 percent) contained specific information addressing the 5 corrective action elements for the deficiencies identified; and
    - did not verify the nursing homes' correction of identified deficiencies by obtaining evidence of correction for four of nine standard surveys (44 percent) before certifying substantial compliance with Federal participation requirements when followup surveys were not conducted.

    Understated deficiency ratings result in inaccurate information on the Nursing Home Compare Web site. The ratings also may affect recommended enforcement actions and the division's method of verifying nursing homes' correction of identified deficiencies before certifying substantial compliance with Federal participation requirements. In addition, the division district offices' practices of not always ensuring the adequacy of correction plans and verifying correction of identified deficiencies by obtaining evidence of correction could have contributed to deficiencies that recurred three or more times from 2006 through 2008. However, we could not conclusively determine that district office practices contributed to these recurring deficiencies because a review of the recurrence of deficiencies under other circumstances was beyond the scope of our review.

The division district offices did not always follow guidance in the manual. According to the district office supervisors, surveyors used their judgment and interpretation of manual guidance in determining deficiency ratings. In addition, surveyors used their judgment in ensuring the adequacy of correction plans and verifying nursing homes' correction of identified deficiencies. Based on our findings that surveyors understated deficiencies, did not ensure that corrective action plans contained specific information addressing the five corrective action elements, and did not verify correction of identified deficiencies, it appears that the surveyors used their judgment in contradiction to guidance in the manual.

16. ***Washington State Did Not Always Verify Correction of Deficiencies Identified During Surveys of Nursing Homes Participating in Medicare and Medicaid*** A-09-13-02039 (July 2015), http://oig.hhs.gov/oas/reports/region9/91302039.pdf
The State agency did not always verify nursing homes' correction of deficiencies identified during surveys in CY 2012 in accordance with Federal requirements. For the 100 sampled deficiencies, the State agency verified the nursing homes' correction of 30 deficiencies but did not have documentation supporting that it had verified the nursing homes' correction of the remaining 70 deficiencies. Specifically, the State agency did not have the nursing homes' evidence of correction for 64 deficiencies and did not document that it had verified the correction of 6 deficiencies during followup surveys. The State agency certified that the nursing homes that had these 70 deficiencies were in substantial compliance with Federal participation requirements; however, the State agency's certifications did not comply with all Federal requirements related to appropriately verifying the nursing homes' correction of these deficiencies. On the basis of our sample results, we estimated that the State agency did not verify nursing homes' correction of deficiencies in accordance with Federal requirements for 1,164 (84 percent) of the 1,390 deficiencies identified during surveys in CY 2012.

    The State agency did not provide adequate guidance and training to its surveyors or establish standardized practices for them to follow when verifying and documenting the correction of deficiencies. Further, the State agency did not have adequate internal controls over retaining documentation to support that it had verified the correction of deficiencies.

17. ***Maryland Generally Complied With Requirements for Medicaid Payments Made to Multi-Medical Center for Nursing Facility Services*** A-03-11-00151 (May 2013), http://oig.hhs.gov/oas/reports/region3/31100151.asp
This was a financial-related review, but we did mention weaknesses with employee background checks and incidents with resident injuries, namely, quality-of-care issues related to this request. In addition, Multi-Medical had some weaknesses in facility practices. Multi-Medical did not apply for a background check on 20 employees prior to their hire date, including 8 employees for whom Multi-Medical had not applied for background checks at the time of our review. Also, Multi-Medical did not properly report to the State agency three unwitnessed incidents during which a resident received an injury caused by an unknown source. Because the State agency's oversight was not always adequate, it did not ensure that Multi-Medical always complied with State and Federal requirements for facility practices.

Listing of All Quality-of-Care-Related False Claims Act Settlements With Nursing Homes: 2010 to the Present

Quality-of-care-related False Claims Act settlements with nursing homes from 2010 to present		**Date**	**Settlement Amount**	**Integrity Obligations**
Substandard care (i.e., provision of worthless services)	Genesis Healthcare et al.	12/14/2015	$600,000	
	Country Villa Health Corp. and the ARBA Group	5/21/2015	$2,380,000 and $1,420,000	CIA
	Extendicare Health Services and Progressive Step	10/3/2014	$28,000,000 and $10,000,000	CIA
	Foundation Health Services	6/13/2014	$750,000	CIA
	GGNSC Holdings	12/31/2012	$613,300	CIA
	Harbor Senior Concepts (assisted living provider)	4/12/2010	$258,000	CIA
	Cathedral Rock	1/7/2010	$628,000	CIA
RUGs fraud (e.g., the provision of medically unnecessary and unreasonable rehabilitation therapy in skilled nursing facilities)		**Date**	**Settlement Amount**	**Integrity Obligations**
	Kindred Healthcare and RehabCare Group	1/12/2016	$125,000,000	CIA
	Wingate Healthcare Inc.	1/12/2016	$3,900,000	CIA
	Essex Group Management	1/12/2016	$1,375,000	CIA
	Christian Homes	12/17/2015	$675,000	CIA
	Agility Health	2/20/2015	$850,000	
	Oceana County Medical Facility	2/20/2015	$150,000	
	Episcopal Ministries to the Aging	9/15/2014	$1,300,000	
	Life Care Services	9/5/2014	$1,300,000	
	CoreCare V	9/5/2014	$525,000	
	Grace Healthcare	3/4/2013	$2,700,000	CIA
	Bethany Lutheran	5/31/2012	$675,000	CIA

Quality-of-care-related False Claims Act settlements with MFCU involvement				
	Extendicare Health Services and Progressive Step	10/3/2014	$28,000,000; and $10,000,000; CIA	
	Foundation Health Services	6/13/2014	$750,000; CIA	

Question 2 Please provide the number of nursing home abuse investigations by HHS OIG in the past five years that resulted in criminal and civil referrals to the Department of Justice. Of those, how many have resulted in prosecution? Please list all referrals by state.

OI Cases Accepted for Prosecution (CY 2011–2015) by Judicial District			
	Criminal Actions	Civil Actions	Money Receivables
Connecticut - State	1	0	-
Rhode Island	0	1	$56,450
Pennsylvania - Eastern	0	1	$100,692
Virginia - Western	1	0	$1,611,347
Georgia - Northern	0	1	$627,772
Michigan - Eastern	1	0	$100
Texas - Western	12	0	$1,200
California - State	3	0	$8,790
California - Northern	0	4	$3,800,000
Total	**18**	**7**	**$6,206,351**

6. Is HHS OIG interfacing with states to ensure that elder abuse is reported, investigated, and prosecuted? If not, why? If so, what resources does it have at its disposal?

MFCU Patient Abuse and Neglect Caseload and Case Results by State for FY 2015					
State MFCU	**Open Investigations (Total)**	**Indicted/ Charged (Criminal)**	**Convictions (Criminal)**	**Amount of Recoveries (Criminal)**	**Amount of Recoveries (Civil)**
Alabama	9	9	4	$0	$0
Alaska	1	0	0	$0	$0
Arizona	19	21	24	$153,025	$0
Arkansas	41	13	11	$65,342	$158,000
California	643	108	56	$718,184	$0
Colorado	0	0	0	$0	$0
Connecticut	4	0	1	$11,697	$0
Delaware	54	10	24	$16,846	$0
DC	6	0	1	$50	$0
Florida	37	24	23	$181,194	$0
Georgia	11	1	0	$0	$0
Hawaii	43	1	2	$26,723	$0
Idaho	10	0	1	$620	$0
Illinois	50	12	13	$157,178	$0
Indiana	390	1	6	$0	$0
Iowa	21	21	20	$29,734	$0
Kansas	8	0	2	$200,000	$0
Kentucky	45	13	10	$1,333	$0
Louisiana	70	7	7	$94,980	$12,083
Maine	11	4	4	$1,570	$0
Maryland	34	4	2	$1,000	$0
Massachusetts	58	1	1	$50	$100,000
Michigan	46	9	7	$493,221	$0
Minnesota	2	2	2	$33,312	$0
Mississippi	509	69	55	$206,890	$0
Missouri	15	4	2	$13,540	$0
Montana	7	1	2	$6,635	$0
Nebraska	28	2	6	$94,534	$0
Nevada	4	0	0	$0	$0
New Hampshire	11	4	0	$0	$0
New Jersey	25	3	6	$340,148	$0
New Mexico	4	0	0	$0	$0

State MFCU	Open Investigations (Total)	Indicted/ Charged (Criminal)	Convictions (Criminal)	Amount of Recoveries (Criminal)	Amount of Recoveries (Civil)
New York	146	43	53	$0	$0
North Carolina	9	3	4	$71,877	$101,694
Ohio	432	36	27	$36,109	$2,597,186
Oklahoma	66	20	15	$67,929	$0
Oregon	6	9	9	$4,339	$0
Pennsylvania	28	4	2	$1,130	$0
Rhode Island	14	9	3	$540	$0
South Carolina	44	6	3	$14,880	$0
South Dakota	0	0	0	$0	$2,335
Tennessee	42	13	12	$50	$0
Texas	146	6	17	$196,962	$0
Utah	20	3	3	$2,021	$0
Vermont	11	0	1	$41,567	$0
Virginia	6	7	7	$1,619,141	$0
Washington	7	3	4	$2,108	$0
West Virginia	19	2	3	$637	$0
Wisconsin	9	0	0	$0	$0
Wyoming	3	0	1	$375	$0
Total	**3,224**	**508**	**456**	**$4,907,470**	**$2,971,297**