



U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES  
**OFFICE OF INSPECTOR GENERAL**

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**Testimony Before the United States Senate  
Committee on Finance**

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**“Promoting Elder Justice: A Call for Reform”**

**Testimony of:**

**Megan H. Tinker**  
Senior Advisor for Legal Affairs  
Office of Counsel to the Inspector General  
Office of Inspector General  
U.S. Department of Health and Human Services

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**Testimony of:  
Megan H. Tinker  
Senior Advisor for Legal Affairs**

**Office of Inspector General, U.S. Department of Health and Human Services**

Good morning, Chairman Grassley, Ranking Member Wyden, and other distinguished Members of the Committee. Thank you for the opportunity to appear before you today to discuss the important topic of quality of care and safety of our Nation's Medicare and Medicaid beneficiaries.

Office of Inspector General (OIG) work has revealed widespread problems in providing safe, high-quality care to Medicare and Medicaid beneficiaries in many settings and ongoing failures to identify, report, and correct incidents of abuse and neglect when they occur. This morning, I will discuss our recent work focusing on abuse and neglect of Medicare beneficiaries, State Survey Agency response to nursing home deficiencies and complaints, and enforcement actions to address misconduct and grossly substandard care.

The three key take-a-ways from my testimony are:

- **First, CMS, States, and providers should use data to ensure potential abuse and neglect is being identified.**
- **Second, CMS, States, and providers must ensure potential abuse and neglect is reported to enable oversight and prevention.**
- **Third, States must ensure deficiencies are corrected.**

## **BACKGROUND**

Approximately 1.4 million Medicare beneficiaries received care in skilled nursing facilities (SNFs) in 2016. Federal expenditures on nursing home care exceed \$70 billion annually, including in 2017 \$43 billion for Medicaid long-term care and \$28 billion for Medicare post-

acute and other skilled care. Most facilities providing these types of care are certified to serve as both nursing homes and SNFs. SNFs provide skilled nursing care and rehabilitation services for residents who require such care because of injury, disability, or illness, typically following a hospital stay.

Ensuring that nursing homes meet Federal requirements for quality and safety is a shared Federal and State responsibility. State Survey Agencies (Survey Agencies) must conduct “surveys” (inspections) of nursing homes at least every 15 months to certify their compliance with these requirements. The Centers for Medicare & Medicaid Services (CMS) provides guidance regarding the survey process in its State Operations Manual (SOM) and Interpretive Guidelines. When Survey Agencies identify deficiencies during their surveys, nursing homes must submit correction plans, and Survey Agencies must verify that the facility corrected its deficiencies.

In addition, Survey Agencies must review all nursing home complaint allegations. A complaint survey can be conducted to investigate an allegation of noncompliance with Federal participation requirements, such as a nursing home providing improper care or treatment to a beneficiary. Where the Survey Agency finds evidence of abuse or neglect it must make a referral to local law enforcement, the Medicaid Fraud Control Unit (MFCU) if appropriate, and the applicable licensure authority. CMS may also take enforcement actions to address nursing home deficiencies, including imposing civil monetary penalties or terminating the nursing home from Medicare and Medicaid.

## **ABUSE AND NEGLECT**

Beneficiary safety and quality of care is a top priority for OIG, and we believe these goals can be better achieved through the effective harnessing of available data. The problems highlighted today are mirrored in other areas OIG has examined. For example, OIG’s work on critical incident reporting at group homes showed that group home providers failed to

report many critical incidents to the appropriate State agencies.<sup>1</sup> These critical incidents included death, physical/sexual assault, serious injuries, and missing persons. In addition, we released two reports earlier this month focused on hospice care.<sup>2</sup> OIG found that from 2012 through 2016, the majority of U.S. hospices that participated in Medicare had one or more deficiencies in the quality of care they provided to their patients. These deficiencies—much like the deficiencies highlighted elsewhere in my testimony—have a human cost on vulnerable beneficiaries and are subject to CMS oversight and enforcement action.

As we reported in an August 2017 Early Alert,<sup>3</sup> OIG reviewed hospital emergency room records from 2015 and 2016 for SNF residents whose injuries may have been the result of potential abuse or neglect in the SNF. We found 134 incidents of potential abuse or neglect across 33 States. For 28 percent of these incidents, we could not determine whether nursing home or hospital staff contacted local law enforcement despite State mandatory reporting laws requiring medical staff to do so. This Early Alert informed CMS that it had inadequate procedures to ensure that incidents of potential abuse and neglect at SNFs are properly identified and reported.

### **Abuse and Neglect Involving SNFs and Emergency Room Visits**

In a June 2019 report,<sup>4</sup> we assessed the prevalence and reporting of incidents of potential abuse or neglect of Medicare beneficiaries residing in SNFs who had a hospital emergency room Medicare claim in calendar year (CY) 2016. **We determined that one in five of these high-risk claims were the result of potential abuse or neglect.**

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<sup>1</sup> OIG, *Connecticut Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries* (A-01-14-00002), May 2016; OIG, *Massachusetts Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries* (A-01-14-00008), July 2016; OIG, *Maine Did Not Comply With Federal and State Requirements for Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities* (A-01-16-00001), August 2017; *Alaska Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities* (A-09-17-020016), June 2019.

<sup>2</sup> OIG, *Hospice Deficiencies Pose Risks to Medicare Beneficiaries* (OEI-02-17-00020), July 2019; *Safeguards Must Be Strengthened To Protect Medicare Hospice Beneficiaries From Harm* (OEI-02-17-00021), July 2019.

<sup>3</sup> OIG, *Early Alert: The Centers for Medicare & Medicaid Services Has Inadequate Procedures to Ensure That Incidents of Potential Abuse or Neglect at SNFs Are Identified and Reported in Accordance With Applicable Requirements* (A-01-17-00504), August 2017.

<sup>4</sup> OIG, *Incidents of Potential Abuse and Neglect at Skilled Nursing Facilities Were Not Always Reported and Investigated* (A-01-16-00509), June 2019.

*Example: A 72-year-old Medicare beneficiary with a history of throat cancer, recent throat surgery, and a nasogastric tube in place was transported to an emergency room (ER) and was diagnosed with aspiration pneumonia. The beneficiary's wife stated that her husband's nasogastric tube had not been suctioned well, and he was not given all of his scheduled tube feeds. In addition, records indicated that the beneficiary was given a meal tray with liquids despite a strict "nothing by mouth" order, putting the patient at risk for aspiration. The combination of the injuries suffered and the allegations made by the beneficiary's family gave reasonable cause to suspect potential neglect of this beneficiary.*

A SNF must ensure that all incidents involving alleged abuse and neglect are reported immediately to the administrator of the facility and to the Survey Agency. **We determined that SNFs failed to report an estimated 6,608 instances of potential abuse or neglect (as identified in high-risk hospital ER Medicare claims) to the Survey Agencies in 2016.**

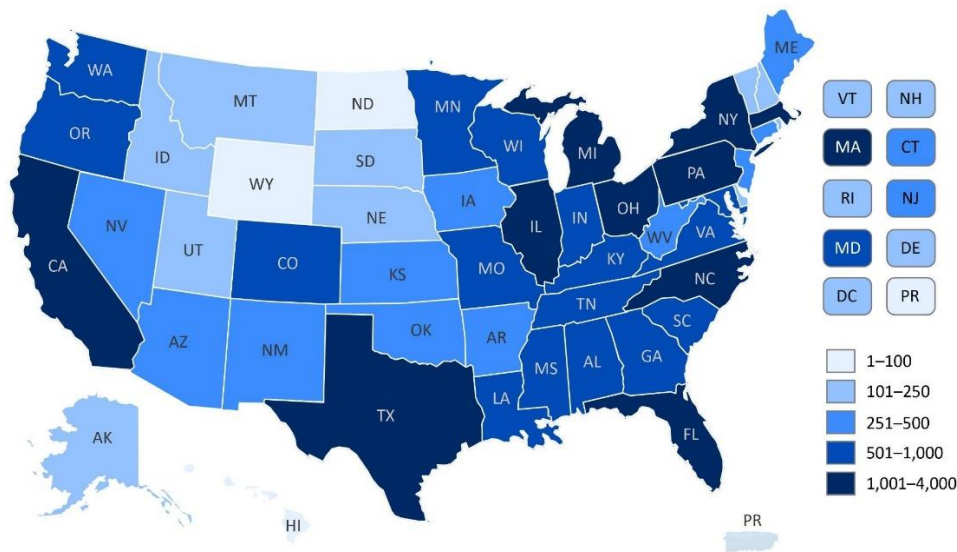
Because of this failure to report, Survey Agencies could not review, prioritize, or conduct immediate onsite investigations, if necessary, to determine whether abuse, neglect, or other violations had occurred. Lastly, we determined that CMS does not require all incidents of potential abuse or neglect and related referrals made to law enforcement to be recorded and tracked in their complaint and incident tracking system.

### **Using Medicare Claim Data to Identify Potential Abuse and Neglect**

In a June 2019 report,<sup>5</sup> we demonstrated that Medicare claims can be used to identify incidents of potential abuse or neglect, regardless of where the beneficiary resides. Further, our work showed that many of these incidents were not reported to law enforcement as required. **Medicare claims data identified more than 30,000 incidents of potential abuse or neglect.** In our review, we identified Medicare claims in all States that contained diagnosis codes indicating the treatment of injuries potentially caused by abuse or neglect of Medicare beneficiaries from January 1, 2015, through June 30, 2017.

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<sup>5</sup> OIG, *CMS Could Use Medicare Data to Identify Instances of Potential Abuse or Neglect* (A-01-17-00513), issued May 2019.



Source: Appendix F, *CMS Could Use Medicare Data to Identify Instances of Potential Abuse or Neglect* (A-01-17-00513)

All of the diagnosis codes were assigned by the health professional who treated the Medicare beneficiaries. Most of the actual *incidents* that caused harm occurred in settings other than medical facilities. Only 10 percent were associated with incidents where the injuries occurred in a medical facility, like a nursing home. Healthcare workers were the likely perpetrators of incidents of potential abuse or neglect in about 7 percent of the claims.

**Approximately 90 percent of the medical records identified by this analysis contained evidence of potential abuse or neglect.** This evidence included, but was not limited to, witness statements and photographs. We estimated that 30,754 claims were supported by medical records that contained evidence of potential abuse or neglect.

**Providers frequently failed to alert law enforcement to incidents of potential abuse or neglect.** Approximately 27 percent of claims were not reported to law enforcement by mandatory reporters even though all States require certain individuals to report suspected abuse, neglect, or exploitation of vulnerable adults.

Section 1150B of the Act and the Federal Conditions of Participation (CoPs) contained in CFR Title 42 for long-term-care facilities, such as nursing homes and SNFs, include

reporting requirements for incidents of suspected abuse or neglect. For these facilities, covered individuals are required to report any reasonable suspicion of a crime, such as certain instances of abuse, neglect, or exploitation. The CoPs for hospitals require that hospitals follow State laws for mandatory reporting. Group homes and assisted-living facilities are covered by State regulations regarding the reporting of potential abuse or neglect, and their employees are generally covered by State laws for mandatory reporting.

## **A GUIDE FOR USING DIAGNOSIS CODES IN HEALTH INSURANCE CLAIMS TO HELP IDENTIFY UNREPORTED ABUSE OR NEGLECT**

We believe that data forms the bedrock of oversight and ensures transparency and accountability. Data is an important means of ensuring the identification, reporting, and correction of incidents of abuse and neglect. Today we are releasing “A Resource Guide for Using Diagnosis Codes in Health Insurance Claims To Help Identify Unreported Abuse or Neglect,” (guide) which explains our approach to using claims data to identify incidents of potential abuse or neglect of vulnerable populations. The guide synthesizes the methodologies that OIG developed in our extensive work on identifying unreported critical incidents, particularly those involving potential abuse or neglect.

The guide includes a flow chart showing key decision points in the process and the detailed lessons that OIG has learned using this approach. **We encourage CMS, States, providers and other public and private sector entities to use this guide to develop a process tailored to their specific circumstances and apply it to any vulnerable population they deem appropriate.** The sources of data could include Medicaid Management Information System claims data, private payor insurance claims data, or similar data sets. Analyzing the data can help identify individual incidents of unreported abuse or neglect, and patterns and trends of abuse or neglect involving specific providers, beneficiaries, or patients who may require immediate intervention to protect their health, safety and rights. The guide also provides technical information, such as examples of medical diagnosis codes, to assist CMS, States, providers and others with analyzing claims data to help combat abuse and neglect.

## CORRECTION OF DEFICIENCIES AT NURSING HOMES

State Survey Agencies perform surveys to determine whether nursing homes<sup>6</sup> meet the Federal Conditions of Participation. From 2015 to 2018, OIG completed audits of nine States and issued a consolidated report to CMS regarding whether the Survey Agency took appropriate steps to verify that nursing facilities had corrected identified deficiencies.<sup>7</sup> **We found that seven States failed to verify or maintain sufficient evidence that they had verified nursing homes' correction of deficiencies as required by Federal rules.**

Specifically, for 47 percent of the sampled deficiencies (326 of the 700), these Survey Agencies did not obtain or maintain evidence of nursing homes' correction of deficiencies. If Survey Agencies certify that nursing homes are in substantial compliance without properly verifying the correction of deficiencies and maintaining sufficient documentation to support the verification of deficiency correction, the health and safety of nursing home residents may be at risk.

In addition, OIG recently issued a data brief<sup>8</sup> that analyzed nursing home deficiencies identified by State Survey Agencies across the nation. Overall, we found that the number of deficiencies slightly increased from CYs 2013 through 2016, then slightly decreased in CY 2017. Also, the overall average number of deficiencies identified by standard and complaint surveys slightly increased from CYs 2013 through 2017, which would suggest that Survey Agencies identified more deficiencies per survey in CY 2017 than they did in CY 2013. **However, approximately 31 percent of nursing homes had a repeat deficiency, i.e., a deficiency type that was cited at least five times in separate surveys.** Further, at least half of these nursing homes experienced an incident of a more serious deficiency, including incidents of substandard quality of care, actual harm, and immediate jeopardy to residents. The results of our data analysis raise questions as to whether the quality of care and services provided to nursing home residents improved during our review period.

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<sup>6</sup> Nursing homes can have both Medicare and Medicaid beneficiaries residing in them.

<sup>7</sup> OIG, *CMS Guidance to State Survey Agencies on Verifying Correction of Deficiencies Needs To Be Improved To Help Ensure the Health and Safety of Nursing Home Residents* (A-09-18-02000), February 2019.

<sup>8</sup> OIG, *Trends in Deficiencies at Nursing Homes Show That Improvements Are Needed To Ensure the Health and Safety of Residents* (A-09-18-02010), April 2019.



## OIG INVESTIGATIONS AND ENFORCEMENT: MISCONDUCT AND SUBSTANDARD CARE

OIG investigates potential criminal and civil violations and pursues administrative actions to hold accountable those who victimize residents of nursing homes. Allegations involving patient harm remain a top OIG enforcement priority. For example, following Hurricanes Irma and Maria, the OIG and other Federal and State agencies undertook an investigation to review potential quality of care issues involving Medicare and Medicaid patients residing at long term care facilities. During the initial phase of this initiative, OIG along with other Federal and State authorities, visited more than 800 homes throughout Puerto Rico.

*Example: The investigation revealed that the owner of one of the facilities physically and verbally abused an 85-year-old female Medicaid beneficiary residing at her long-term-care facility. The owner verbally insulted the resident and punched her and hit her with a broomstick. The owner also negligently caused other patients residing at the facility to develop malnutrition and scabies. For patient safety, all residents were removed and transferred to other long-term-care facilities. The owner pleaded guilty to all five charges against her and was sentenced to 8 years of imprisonment to be served in home detention.*

In other instances, facility-wide or chain-wide grossly substandard care has resulted in harm to patients. Such cases may result in False Claims Act resolutions or administrative actions, such as exclusion from participation in Federal healthcare programs. Patient neglect is a recurring issue in False Claims Act cases. **Allegations in these cases have included avoidable pressure ulcers; overmedication, which may lead to falls and fractures; failure to follow physicians' orders; and failure to provide a habitable living environment, with concerns including mold and roof leaks.** In resolving False Claims Act cases, OIG may enter into “quality of care” corporate integrity agreements (CIAs) with nursing homes or chains that require actions to improve quality of care and safety. OIG is currently monitoring quality of care CIAs covering more than 200 nursing homes. OIG also collaborates closely with the 52 State Medicaid Fraud Control Units (MFCUs) that often have primary responsibility for enforcement of cases of abuse and neglect in health facilities, including nursing homes, as well as assisted living facilities.

## **ADDITIONAL CORRECTIVE ACTION IS NEEDED**

To help ensure the health and safety of Medicare and Medicaid beneficiaries, the reports that I have referenced in this testimony, as well as numerous other OIG reports related to quality of care and nursing homes, have recommended that CMS take specific actions to improve this area of the program. A complete listing of significant unimplemented OIG recommendations as well as CMS's response to those recommendations can be found in our *Solutions to Reduce Fraud, Waste, and Abuse in HHS Programs: Top Recommendations*. The following is a list of some of our recommendations related to my testimony today:

- CMS should compile a list of diagnosis codes that indicate potential abuse or neglect, conduct periodic data extracts, and inform States that the data are available to help the States ensure compliance with their mandatory reporting laws.
- CMS should take action (e.g., provide training, clarify guidance) to ensure that incidents of potential abuse or neglect of Medicare beneficiaries residing in SNFs are identified and reported.
- CMS should assess the sufficiency of existing Federal requirements to report suspected abuse and neglect of Medicare beneficiaries, regardless of where services are provided, and strengthen those requirements or seek additional legislative authorities if appropriate.
- CMS should improve its guidance to State Agencies on verifying nursing homes' correction of deficiencies and maintaining documentation to support verification.

## **CONCLUSION**

CMS and law enforcement cannot adequately protect victims of abuse and neglect from harm if they do not first know the harm is occurring. Failing to leverage the data available represents a lost opportunity for CMS and public and patient safety organizations to identify and pursue legal, administrative, and other appropriate remedies to ensure the safety, health, and rights of Medicare and Medicaid beneficiaries.

HHS, CMS, and OIG are committed to the health and safety of beneficiaries. Despite this shared commitment, the data and findings that we are presenting today are extremely troubling and should cause all of us to redouble our efforts to protect the most vulnerable of our beneficiaries from these disturbing incidents. We need to use all the tools at our disposal to effectively address the issues of abuse and neglect highlighted in my testimony. We believe that Medicare and Medicaid data is a critical tool and that CMS can do a better job of analyzing and sharing that data so that States can promote better health and safety outcomes and manage their programs more effectively. We created the guide that we are releasing today to support CMS, States, providers, and others in their efforts to curtail this ongoing problem of abuse and neglect of our most vulnerable beneficiaries.

Thank you for your ongoing leadership in this area and for affording OIG the opportunity to appear before you today.