U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

Statement for the Record for the United States House of Representatives Committee on Ways and Means

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"Caring for Aging Americans"

Statement for the Record

Office of Inspector General
Department of Health and Human Services

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The Office of Inspector General (OIG) for the Department of Health and Human Services (HHS) appreciates the opportunity provided by the U.S. House of Representatives Committee on Ways and Means to submit a statement for the record in connection with the Committee's hearing titled "Caring for Aging Americans." OIG's statement for the record outlines its work involving the safety and health of beneficiaries in hospice care, nursing homes, skilled nursing facilities, long-term-care hospitals, inpatient rehabilitation hospitals, and group homes. OIG is charged with overseeing all HHS programs and operations. We combat fraud, waste, and abuse; promote efficiency, economy, and effectiveness; safeguard taxpayer dollars, and protect the beneficiaries the programs serve. To accomplish this, OIG employs tools such as data analysis, audits, evaluations, and investigations. We are a multidisciplinary organization comprising investigators, auditors, evaluators, analysts, clinicians, and attorneys. Over the years, we have developed an extensive body of work reviewing the occurrence and preventability of adverse events and abuse and neglect in the care facilities that are central to the well-being of many elderly Americans. Our work has yielded reports and recommendations, which we discuss below.

Hospice Care

Hospice is an increasingly important benefit for the Medicare population. And the Medicare hospice benefit is growing—from 2006 to 2016, Medicare spending for hospice care increased 81 percent to $16.7 billion, and the number of beneficiaries using the hospice benefit rose 53 percent to over 1.4 million. Hospice care can provide great comfort to beneficiaries, their families, and caregivers at the end of a beneficiary's life. Those in hospice have the right to be free from abuse, neglect, and other harm. When hospices cause harm or fail to take action when harm is caused by others, beneficiaries are deprived of these basic rights. OIG is committed to ensuring that beneficiaries receive quality care and to safeguarding the hospice benefit. OIG has completed extensive oversight work on the hospice program, including numerous evaluations and audits. This work identified significant vulnerabilities in the Medicare hospice benefit and found that hospices sometimes failed to provide needed services to beneficiaries and sometimes provided poor quality care. OIG has also conducted criminal and civil investigations of hospice providers, leading to the conviction of individuals, monetary penalties, and civil False Claims Act settlements.

OIG released two reports which 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. Some Medicare beneficiaries were seriously harmed when hospices provided poor care or failed to take action in cases of abuse.

In our report *Hospice Deficiencies Pose Risks to Medicare Beneficiaries* (OEI-02-17-00020), July 2019, we found that the most common types of deficiencies involve poor care planning, mismanagement of aide services, and inadequate assessments of patients. Over 300 hospices had at least one serious deficiency or at least one substantiated severe complaint in 2016, which we considered to be poor performers. These hospices represent 18 percent of all hospices surveyed nation-wide in 2016.

The findings in this report provide further evidence that the Centers for Medicare & Medicaid Services (CMS) should implement existing OIG recommendations to strengthen the survey process, establish additional enforcement remedies, and empower beneficiaries and their caregivers to make better informed decisions about hospice care. Specifically, CMS should: (1) expand the deficiency data that accrediting organizations report to CMS and use these data to strengthen its oversight of hospices; (2) take the steps necessary to seek statutory authority to include information from accrediting organizations on Hospice Compare, CMS's website that contains limited information about individual hospices; (3) include on Hospice Compare the survey reports from State agencies; (4) include on Hospice Compare the survey reports from accrediting organizations, once authority is obtained; (5) educate hospices about common deficiencies and those that pose particular risks to beneficiaries; and (6) increase oversight of hospices with a history of serious deficiencies.

In our report *Safeguards Must Be Strengthened to Protect Medicare Hospice Beneficiaries From Harm* (OEI-02-17-00021), July 2019, OIG describes 12 cases of harm to hospice beneficiaries and identifies vulnerabilities in CMS's efforts to prevent and address harm. These vulnerabilities include insufficient reporting requirements for hospices, limited reporting requirements for surveyors, and barriers that may impede beneficiaries and caregivers from registering complaints. Also, these hospices did not face serious consequences for the harm described in this report. Specifically, surveyors did not always cite immediate jeopardy in cases of significant beneficiary harm, and hospices' plans of correction are not designed to address underlying issues. In addition, CMS cannot impose penalties, other than termination, to hold hospices accountable for harming beneficiaries.

CMS must address these vulnerabilities. To effectively protect beneficiaries from harm, CMS needs enforcement tools, as we have recommended in the past. CMS must also strengthen safeguards to protect Medicare hospice beneficiaries from harm. Specifically, CMS should (1) strengthen requirements for hospices to report abuse, neglect, and other harm; (2) ensure that hospices educate their staff to recognize signs of abuse, neglect, and other harm; (3) strengthen guidance for surveyors to report crimes to local law enforcement; (4) monitor surveyors' use of immediate jeopardy; and (5) improve and make user-friendly the process for beneficiaries and caregivers to make complaints.

Nursing Homes, Skilled Nursing Facilities, Long-Term-Care Hospitals, Inpatient Rehabilitation Hospitals, and Group Homes

High-quality nursing homes can deliver enormous benefit as places of comfort and healing. For Medicare beneficiaries, nursing homes provide a clinically managed recovery period after illness and injury that can make the difference between more good years ahead or a downward spiral. For long-term-care residents and their families, often insured through Medicaid, nursing homes can provide responsible and much-needed care to those in fragile health.

Many nursing homes provide excellent care and diligently protect their residents. But an alarming number of residents are subject to costly medical harm, unsafe conditions, and abuse and neglect, much of it preventable with better practices and oversight. Nursing home care is a critical component of the continuum of care. Quality and safety of care in nursing homes affect the provision and cost of care in other settings. With an aging population and heightened focus on value-driven care, it is increasingly critical that Federal and State funds are used to purchase safe, high-quality care for vulnerable elderly and disabled patients.

CMS and States share responsibility for ensuring that nursing homes meet Federal requirements for quality and safety. CMS requires State agencies to conduct a "survey" (inspection) of nursing homes at least every 15 months to certify each facility's compliance. CMS oversees the State certification process and provides guidance regarding the survey process in its State Operations Manual and Interpretive Guidelines. When State Agencies identify deficiencies during their surveys, nursing homes must submit correction plans, and State Agencies must verify that the facility corrected its deficiencies. CMS and State Medicaid agencies may also take enforcement actions to address nursing home deficiencies, including imposing civil monetary penalties or terminating the nursing home from the Medicare program.

Most nursing homes are certified to serve as both long-term-care facilities and skilled nursing facilities (SNFs). SNFs render skilled nursing care and, in most cases, skilled rehabilitative services and other related healthcare services to help patients recover from injury, disability, or illness, typically following a hospital stay. Skilled nursing care is given or supervised by registered nurses. Examples of skilled nursing care include administering intravenous drugs, injections, or tube feedings; changing dressings; and disease-management education. Skilled rehabilitative services include physical therapy, occupational therapy, and speech therapy. Medicare does not consider skilled services to include any service that could be performed safely by a nonmedical person without the supervision of a nurse. Approximately 1.4 million Medicare beneficiaries received care in 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.

OIG found, in our report *Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries* (OEI-06-11-00370), February 2014, that one in three SNF patients experienced adverse events during their nursing home stays, including infections, pressure ulcers, and misuse of medication. In a nation-wide review, OIG found that one-third of patients in SNFs experienced harm from the care provided in the nursing homes and more than half of the harm (adverse events) were preventable if the facilities had provided better care. This report was one in a decade-long OIG series regarding adverse events in various healthcare settings, including hospitals. The adverse events OIG identified in nursing homes resulted in a range of harmful outcomes for beneficiaries, including extended stays in the SNF, transfers to hospital emergency departments, and the need for life-sustaining intervention. For 6 percent of the adverse events, the harm contributed to residents' death. Over half of the patients who experienced harm returned to a hospital for treatment, incurring millions of dollars in additional Medicare expenditures. OIG's work in this realm also includes our report *Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries* (OEI-06-09-00090), November 2010, and will continue with our upcoming Work Plan item *Adverse Events in Hospitals:*

National Incidence Among Medicare Beneficiaries—10-Year Update, OEI-06-18-00400, estimated in late 2020.

Some adverse events involved medical errors such as supplying incorrect medication, but most preventable harm resulted from daily substandard care, such as inadequate resident monitoring and failure or delay of necessary care. For these adverse events, patients and families often attribute bad outcomes to the underlying disease process without realizing that failures of care caused or contributed to the harm.. Nursing home staff also failed to identify harm in some cases; for example, a number of adverse events started with dehydration, which can quickly result in kidney damage. One nursing home resident died of cardiac arrest after progressive kidney failure that was not detected until the resident was awaiting discharge from the SNF.

A shift in thinking about the care provided in nursing homes is needed. Our adverse events work shows that nursing home residents often had care needs similar to patients in hospitals, with residents sometimes seriously ill and impaired. The hospital community has focused keenly on patient safety and, while still experiencing high harm rates in some categories, has made substantial changes in the provision of patient care and safety systems. Sustained improvements in nursing homes will require a cultural shift that recognizes clinical harm and elevates reduction of harm as a priority for nursing home care.

The foundation of OIG's recommendations to reduce harm is that CMS (and the Agency for Healthcare Research and Quality) raise awareness of adverse events in nursing homes (and other post-acute-care settings) with the same methods used to promote hospital safety. Broadening these and other patient safety improvement efforts to include the nursing home environment would ensure that safe care practices promoted in acute care hospitals extend to the critical periods of post-acute recovery and long-term care. To address the high rate of harm in nursing homes, OIG made two recommendations to CMS: (1) provide guidance to nursing homes about detecting and reducing harm to be included in facility Quality Assurance and Performance Improvement programs, and (2) instruct State agencies to review facility practices for identifying and reducing adverse events, and link related deficiencies specifically to resident safety practices. OIG determined that CMS fully implemented these recommendations on adverse events in SNFs as of August 2018. It is too early to assess the effectiveness of CMS's actions in changing practices, but they hold promise for improving quality of care and reducing adverse events for nursing home residents.

OIG has also studied patient safety in long-term-care hospitals (LTCHs) and inpatient rehabilitation hospitals. LTCHs are inpatient hospitals that provide long-term care to clinically complex patients, such as those with multiple acute or chronic conditions. Medicare beneficiaries typically enter LTCHs following an acute-care hospital stay to receive intensive rehabilitation and medical care. LTCHs are the third most common type of post-acute-care facility after SNFs and inpatient rehabilitation hospitals. In our report *Adverse Events in Long-Term-Care Hospitals: National Incidence Among Medicare Beneficiaries* (OEI-06-14-00530), November 2018, OIG found that 21 percent of Medicare patients in LTCHs experienced adverse events, which are particularly serious instances of patient harm resulting from medical care. The four categories of adverse events include outcomes such as prolonging a patient's LTCH stay or necessitating transfer to another facility; requiring life-saving intervention; resulting in

permanent harm; and contributing to death. Five percent of Medicare patients in LTCHs experienced adverse events that contributed to or resulted in their deaths. An additional 25 percent of patients experienced temporary harm events, which are patient harm that required medical intervention but did not cause lasting harm. The overall percentage of patients in LTCHs who experienced either type of harm (adverse events or temporary harm events) is 46 percent, higher than OIG found in hospitals (27 percent), skilled nursing facilities (33 percent), and rehabilitation hospitals (29 percent). Patient stays in LTCHs present more opportunities for harm events because the stays are longer, but the number of harm events per patient day was similar between LTCHs and other post-acute-care settings and lower than in non-LTCH acute-care hospitals. Over half of these adverse events and temporary harm events (54 percent of harm events) were clearly or likely preventable. Preventable harm events were often related to substandard care (58 percent) and medical errors (34 percent). Forty-five percent of harm events were found to be clearly or likely not preventable, often because the patients were highly susceptible to harm due to other health conditions or poor overall health.

OIG has also examined adverse events in rehabilitation (rehab) hospitals. Rehab hospitals are post-acute providers that specialize in intensive rehabilitative care for patients recovering from illness, injury, or surgery. In our report *Adverse Events in Rehabilitation Hospitals: National Incidence Among Medicare Beneficiaries*, (OEI-06-14-00110), July 2016, OIG found that an estimated 29 percent of Medicare beneficiaries experienced adverse or temporary harm events during their rehab hospital stays, resulting in temporary harm; prolonged stays or transfers to other hospitals; permanent harm; life-sustaining intervention; or death. This harm rate is in line with what we found in hospitals (27 percent) and in SNFs (33 percent). Physician reviewers determined that 46 percent of these adverse and temporary harm events were clearly or likely preventable. Physicians attributed much of the preventable harm to substandard treatment, inadequate patient monitoring, and failure to provide needed treatment. Nearly one-quarter of the patients who experienced adverse or temporary harm events were transferred to an acute-care hospital for treatment, with an estimated cost to Medicare of at least $7.7 million in 1 month, or at least $92 million in 1 year, assuming a constant rate of hospitalization throughout the year.

Concerns about unreported abuse and neglect in nursing homes persist. For example, in our report *Incidents of Potential Abuse and Neglect at Skilled Nursing Facilities Were Not Always Reported and Investigated* (A-01-16-00509), June 2019, OIG 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 2016. We determined that one in five of these high-risk claims may have resulted from abuse or neglect. 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 emergency room 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. We recommended that CMS take action to ensure that incidents of potential abuse or neglect of Medicare beneficiaries residing in SNFs are identified and reported by

working with the survey agencies to improve training for staff of SNFs on how to identify and report incidents of potential abuse or neglect of Medicare beneficiaries; clarifying guidance to define and provide examples of incidents of potential abuse or neglect; requiring the survey agencies to record and track all incidents of potential abuse or neglect in SNFs and referrals made to local law enforcement and other agencies; and monitoring the survey agencies' reporting of findings of substantiated abuse to local law enforcement.

Medicare claims can be used to identify incidents of potential abuse or neglect, regardless of where the beneficiary resides. As shown in our report *CMS Could Use Medicare Data to Identify Instances of Potential Abuse or Neglect* (A-01-17-00513), June 2019, many incidents of potential abuse or neglect 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. 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, such as 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. Despite laws in every State requiring healthcare professionals to report suspected abuse or neglect or exploitation of vulnerable adults, providers frequently failed to alert appropriate authorities. Approximately 27 percent of claims were not reported to law enforcement by mandatory reporters.

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 must 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.

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.[1] These critical incidents

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[1] 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*

included death, physical/sexual assault, serious injuries, and missing persons.   OIG believes that improved data collection and analysis can improve patient safety and quality of care.

OIG released "A Resource Guide for Using Diagnosis Codes in Health Insurance Claims To Help Identify Unreported Abuse or Neglect," (guide) in July 2019 to provide assistance with data collection. The guide instructs how to use 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.

Further, a listing of significant unimplemented OIG recommendations related to abuse and neglect, as well as CMS's response to those recommendations, can be found in our report *Solutions to Reduce Fraud, Waste, and Abuse in HHS Programs: Top Recommendations*, July 2019. Some of these recommendations include (1) 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; (2) 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; (3) 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; and (4) CMS should improve its guidance to State Agencies on verifying nursing homes' correction of deficiencies and maintaining documentation to support verification.

Correction of Deficiencies at Nursing Homes

State survey agencies perform surveys to determine whether nursing homes meet the Federal CoPs. From 2015 to 2018, OIG completed audits of nine States and issued a consolidated report (*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) to CMS regarding whether the survey agency took appropriate steps to verify that nursing facilities had corrected identified deficiencies. 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

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Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities (A-09-17-020016), June 2019.

(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 issued a data brief (*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) 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.

Ongoing Work

OIG has ongoing work on quality of nursing home care. For example, OIG has two ongoing reports about staffing at nursing homes as reported by the Payroll-Based Journal (PBJ), an auditable database of payroll information that each nursing home must submit to CMS each quarter. CMS uses the PBJ to populate the staffing component of the Nursing Home Compare website and analyze staffing patterns. The first report will describe nurse staffing levels as reported in the PBJ, and the second report will examine CMS's efforts to ensure the accuracy of PBJ data and use the data to help improve resident quality of care.

Additional ongoing work reexamines the extent to which State survey agencies met required timeframes for investigating the most serious nursing home complaints, after finding that some States fell short between 2011 and 2015. In October 2019, OIG released an updated "Trends in Nursing Home Complaints" online interactive map with nursing home complaint data from 2016 through 2018. A forthcoming report will offer insights on those States that previously fell short in timely investigation of the most serious nursing home complaints and other trends that raise questions.

Finally, OIG also has ongoing work related to facility-initiated discharges from nursing homes. The forthcoming reports will describe the extent to which State long-term care ombudsmen address facility-initiated discharges and the extent to which State survey agencies investigated and took enforcement actions against nursing homes for inappropriate facility-initiated discharges. This work will also determine the extent to which nursing homes meet CMS requirements for facility-initiated discharges.

Conclusion

OIG continues to prioritize overseeing the care for aging Americans and protecting the safety and health of beneficiaries in hospice care, nursing homes, skilled nursing facilities, long-term-care hospitals, inpatient rehabilitation hospitals, and group homes, and we are committed to helping to reduce adverse events and prevent abuse and neglect in these facilities. We will continue to leverage our analytic, investigative, and oversight tools, as well as our partnerships with the program integrity community, the Department, and Congress to ensure these vulnerable populations are better served. Thank you for affording OIG this opportunity to highlight our important work, and please do not hesitate to contact us with any further questions.