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August 27, 2019

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Ave., S.W.
Washington, DC 20201

Dear Administrator Verma:

I am writing to express my extreme concern about the results of a Department of Health and Human Services Office of the Inspector General (HHS OIG) investigation, which examined high-risk Emergency Department (ED) admissions from skilled nursing facilities (SNFs). The report revealed that up to 20 percent of these admissions were the result of abuse or neglect that was neither reported to state survey agencies nor local law enforcement.[1] I request that the Centers for Medicare & Medicaid Services (CMS) routinely examine high-risk ED claims using the methodology developed by HHS OIG to identify unreported cases of abuse and neglect in SNFs. CMS should add this technique to its current oversight arsenal to protect vulnerable Medicare beneficiaries in SNFs and other institutional settings.

HHS OIG developed a new methodology to identify abuse and neglect of Medicare beneficiaries through an analysis of high-risk ED claims data. HHS OIG analyzed 37,607 claims data for nursing home patients who were admitted to EDs from SNFs in 2016. The 580 different diagnosis codes examined included data elements such as ED admissions for head injuries, bodily injuries, sexual assault, safety, and medical issues. The high-risk claims involved 34,820 of the approximate 1.9 million beneficiaries residing in SNFs during calendar year 2016. The cost of these claims to Medicare was $163 million. Using this methodology, HHS OIG uncovered many disturbing cases of unreported abuse, neglect, and sexual assault in SNFs.

HHS OIG verified that one in five high-risk claims were the result of abuse or neglect. Of the over 37,000 high-risk ED claims HHS OIG examined, almost 8,000 were estimated to be potential abuse and neglect of Medicare beneficiaries residing in SNFs. These were not minor or ambiguous incidents – they included staff-perpetrated broken femurs, cracked skulls, and sexual abuse.

HHS OIG estimated that 80 percent of these incidents were never reported to survey agencies, as required by federal law. HHS OIG's in-depth review of a sample of 51 high-risk ED claims determined to be abuse or neglect determined that SNFs never reported 43 of these cases (or 84 percent) to the state survey agencies. The unreported incidents were so profound that HHS OIG provided CMS with an Early Alert of its results back in August 2017 so that CMS could take immediate action.

Survey agencies are not reporting substantiated abuse to local law enforcement. HHS OIG investigated five survey agencies and found that the agencies had only reported to law enforcement two of the 69 incidents in SNFs that the survey agency had investigated and identified as resident abuse. This is unacceptable.

The ACTS system is being underused. CMS designed the Automated Survey Processing Environment Complaints/Incidents Tracking System (ACTS) to track, process, and report complaints and incidents reported against health care providers and suppliers that CMS regulates. The system was intended to manage all operations associated with complaint and incident processing. HHS OIG found that CMS guidance failed to require all incidents of potential abuse to be entered in the ACTS database and recommended the agency issue new, clearer guidance.

CMS should use HHS OIG methodology to investigate potential abuse in SNFs on an ongoing basis. CMS should use this novel approach in its SNF oversight. HHS OIG also used this methodology to identify potential cases of abuse in group homes and found these group homes did not report up to 15 percent of critical incidents to the appropriate state agencies.[2] The methodology has also identified abuse among non-institutionalized Medicare beneficiaries.[3] Without a doubt, this methodology should be added to CMSs arsenal of approaches to identify and prevent abuse of vulnerable residents of SNFs.

In light of this extremely disturbing report, I request that you provide the following information.

1) In August 2017, CMS received the Early Alert from HHS OIG because HHS OIG believed the cases of unreported abuse they were uncovering demanded immediate attention.
    a. Based on this alert, did CMS identify unreported cases of abuse and follow-up?
    b. Has CMS issued citations for these unreported cases HHS OIG uncovered? If so, please provide data on all citations issued. If not, why have citations not been issued for these clear cases of abuse and/or harm of SNF residents?
    c. Please provide data on the facilities with more than one unreported case of resident abuse captured in the HHS OIG report.

2) Given the high incidence of unreported abuse and neglect HHS OIG found, I request that you immediately begin using the HHS OIG methodology outlined in the report to routinely examine high-risk ED admissions from SNFs to uncover cases of unreported abuse and neglect.

a. Please use this methodology to immediately examine all high-risk ED admissions from SNFs in 2017 and 2018, review the data and summarize the number of these claims that are likely the result of abuse/neglect, sort by type of abuse/neglect, and compare those numbers and types of abuse longitudinally to the unreported abuse in 2016 that was detailed in the HHS OIG report. Please submit this report to the Committee on Ways and Means no later than December 2019.
b. Please continue to conduct this analysis of high-risk ED admissions to SNFs on a quarterly basis and include a report to the Committee on Ways and Means annually, with longitudinal results.

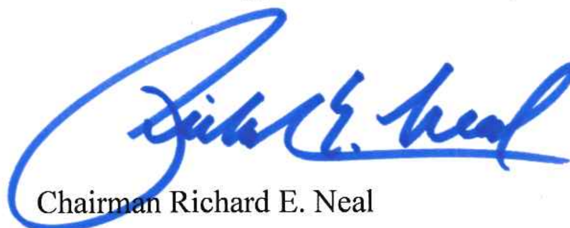
3) What is CMS currently doing to ensure that SNFs are reporting potential cases of abuse and neglect to survey agencies and law enforcement?
    a. Please identify specific strategies CMS has taken and will take to ensure consistent reporting to survey agencies and law enforcement.
    b. What are the penalties SNFs incur for not reporting cases of abuse or neglect to survey agencies and law enforcement?
    c. Please provide the Committee with data on all the fines that have been levied on nursing homes for failing to report cases of abuse or neglect to 1) survey agencies and 2) law enforcement.

4) Please provide an update on CMS's plan to issue new, clearer guidance on the use of the ACTS database.

Every American has a right to live free from abuse and neglect. This HHS OIG report has proven without a doubt that Medicare beneficiaries are not being protected as they should be. The detailed accounts of unreported abuse should incite immediate action on the part of HHS – and HHS OIG has supplied a solution. By adding an analysis of specific high-risk ED claims to its oversight arsenal, CMS would improve its ability to detect abuse and neglect in nursing homes and help to keep Medicare beneficiaries safe.

Given the urgency of this report, please respond within 14 days to Amy Hall (Amy.Hall@mail.house.gov) or Rachel Dolin (Rachel.Dolin@mail.house.gov) of the Ways and Means Health Subcommittee staff at 202-225-3625.

Sincerely,



Chairman Richard E. Neal

[1] Department of Health and Human Services, "Incidents of Abuse or Neglect at Skilled Nursing Facilities were not Always Reported and Investigated. June 2019. A-01-16-00509.
https://oig.hhs.gov/oas/reports/region1/11600509.pdf

[2]" U.S Department of Health and Human Services, Office of the Inspector General, Administration for Community Living, and Office for Civil Rights. "Joint Report: Ensuring Beneficiary Health and Safety in Group Homes Through State Implementation of Comprehensive Compliance Oversight." January 2018.
https://www.oig.hhs.gov/reports-and-publications/featured-topics/group-homes/group-homes-joint-report.pdf

[3] Department of Health and Human Services. Office of Inspector General. "CMS Could Use Medicare Data to Identify Instances of Potential Abuse or Neglect. June 2019. https://oig.hhs.gov/oas/reports/region1/11700513.pdf