

Testimony of:
Gregory E. Demske
Office of Counsel to the Inspector General
U.S. Department of Health and Human Services

Good morning, Chairman Kohl, Ranking Member Smith, and distinguished members of the Committee. I am Gregory Demske, Assistant Inspector General for Legal Affairs in the Office of Inspector General of the Department of Health and Human Services. I appreciate the opportunity to appear before you today to discuss our work related to identifying and preventing the abuse of the elderly. OIG shares your commitment to ensuring the proper oversight of programs designed to serve this Nation's elderly with particular emphasis on the safety and well-being of this population. I look forward to discussing with you today some of the ways OIG seeks to fulfill this goal.

A large portion of OIG's work is aimed at identifying and recommending methods to minimize inappropriate payments, identifying ways to close loopholes that enable unscrupulous providers to defraud Federal health care programs, and examining payment and pricing methods to ensure that Medicare and Medicaid, those programs' beneficiaries, and taxpayers realize good value for program expenditures. Ensuring that appropriate payments are made for properly rendered services also reduces the possibility that the elderly are incurring unnecessary financial liabilities, such as copayments and deductibles, stemming from fraudulently billed services.

However, OIG also conducts reviews to identify whether beneficiaries are able to promptly obtain needed health care services and monitors oversight activities designed to ensure that beneficiaries receive quality services. In particular, OIG has long been concerned with the quality of care rendered in nursing facilities. OIG efforts are threefold: to evaluate the programs and systems involved in oversight of quality of care, to work with State and Federal agencies to investigate and prosecute cases of egregiously substandard care, and to provide guidance to providers to aid in their efforts to promote high quality care.

In my testimony today, I will describe the spectrum of studies, enforcement actions, and initiatives that OIG has undertaken to identify cases of elder abuse, ensure that those who would harm the elderly are prosecuted to the fullest extent of the law and/or prevented from continuing to participate in Federal health care programs, identify where the programs and systems involved in the oversight of quality of care may be strengthened, and promote practices that will help prevent these abuses from occurring.

OVERSIGHT OF MECHANISMS DESIGNED TO ENSURE QUALITY OF CARE

OIG has produced a large body of work related to quality-of-care issues in Federal health care programs in a variety of settings, such as hospitals, nursing homes, and clinical trials. Quality-of-care issues in nursing homes have been of particular concern for OIG over the past decade because of the increasing number of beneficiaries in these settings and the vulnerabilities associated with this population.

With respect to Medicare and Medicaid services rendered in long-term care settings, we have examined a variety of factors that may affect the provision of quality care. First, we have done extensive work in examining the effectiveness of oversight and enforcement mechanisms used by the Centers for Medicare & Medicaid Services (CMS), its contractors, and the States. Second, we have reviewed mechanisms used to screen potential employees of long-term care facilities. And third, much of our work has focused on determining whether providers are potentially harming beneficiaries by taking advantage of financial incentives under various Medicare and Medicaid reimbursement systems to provide too few needed services, to end care too soon, “ping-pong” Medicare beneficiaries among different care settings, or limit access to potentially less profitable patients. I will discuss each of these in turn.

Oversight and Enforcement Mechanisms

Regulating nursing homes that participate in the Medicare and Medicaid programs is primarily the responsibility of CMS and State agencies through their survey and certification efforts. Through periodic facility inspections and individual complaint investigations, CMS and the State agencies assess nursing home performance and determine whether to certify facilities for participation in Medicare and Medicaid. Nursing facility certification is required by statute at least every 15 months, and the statewide average interval between certification of facilities cannot exceed 12 months. States are required to refer case information to CMS for enforcement action when facilities are found to be out of compliance for designated time periods or have deficiencies that put residents in immediate jeopardy. Enforcement actions are mandatory to address particularly egregious cases of noncompliance. Enforcement actions can include termination of the facility’s Medicare contract and denial of payment for new admissions. Other enforcement actions include corrective action plans, civil monetary penalties, required changes in management, and decertification, all administered by CMS.

In a March 2003 report, OIG reviewed trends in survey and certification deficiencies as well as the effectiveness and consistency of the survey and certification process. For the time period studied (1998-2001), OIG determined that a large number of nursing homes had been cited for substandard care and that the number of deficiencies had increased. In addition, our work identified inconsistencies in the way in which deficiencies were cited by the various State survey agencies. These inconsistencies resulted from variations in survey focus, unclear guidelines, lack of a common review process for draft survey

reports, and high turnover of surveyor staff. We recommended that CMS improve guidance to State agencies on citing deficiencies by providing guidelines that are both clear and explicit and that CMS, together with States, develop common review criteria for draft survey reports. CMS has since issued guidance on assessing the severity of deficiencies related to quality of care and quality of life and is currently developing guidance to address other deficiencies.

More recent work has focused on CMS and State enforcement mechanisms against nursing homes that are out of compliance for designated time periods or have deficiencies that put residents in immediate jeopardy. For example, in an April 2005 report, OIG found that although \$81.7 million in civil monetary penalties (CMP) were imposed during 2000 and 2001, CMS had collected only \$34.6 million (42 percent) by the end of 2002. The unpaid portion included reductions resulting from nursing homes waiving their right to appeal, settlements and reductions resulting from appeals, payment delays caused by appeals or bankruptcy proceedings, and nonpayment of collectible CMPs. We also found that CMS did not utilize the full dollar range allowed for CMPs and impositions were frequently at the lower end of the allowed ranges. Low imposition rates and slow and/or difficult collection efforts may minimize the effect that CMPs ultimately have on noncompliant facilities. A more recent OIG report, issued May 2006, found that for the majority of cases requiring mandatory termination of nursing facilities, CMS did not apply the remedy because of both late case referrals by States and CMS staff's reluctance to impose this severe remedy. Based on the findings of these reports, we recommended that CMS provide guidance to regional CMS staff and States regarding appropriate CMP dollar ranges for types of violations and take required collection steps. We also recommended that CMS terminate noncompliant facilities' participation in the Medicare and Medicaid programs within the required timeframe. CMS has taken a number of actions, including implementing both case and incident-tracking systems, that should help to ensure that enforcement actions are properly taken when warranted and implemented more timely.

The Omnibus Budget Reconciliation Act of 1987 requires States to provide timely review of complaints and to investigate allegations of neglect, abuse, and misappropriation of resident property. In a July 2006 review, OIG found that State agencies did not investigate some of the most serious nursing home complaints within the required timeframe and that CMS's oversight of nursing home complaint investigations is limited. We recommended that State agencies be required to meet the 10-day timeframe for investigating complaints alleging actual harm (high) and that CMS eliminate its advance notice requirement for the Federal oversight and support surveys to allow its regional offices to more fully oversee State agencies' investigations of the most severe complaints. CMS has since updated the State Performance Standard, which it uses to hold State agencies accountable for the timeliness of their complaint investigations, to make the timeframe consistent with the 10-day requirement in its "State Operations Manual."

As part of our work looking at quality-of-care oversight in other long-term care settings, in April 2007, we released a report on the certification and oversight of Medicare

hospices. This report found that 14 percent of hospices were past due for certification and, on average, had not been surveyed for 9 years—3 years longer than the CMS standard at that time. OIG also found that health deficiencies were cited for 46 percent of hospices surveyed and for 26 percent of hospices investigated for complaints. The most frequent health deficiencies cited centered on patient care planning and quality. For instance, OIG found that written care plans often were not prepared, lacked important elements, or did not contain sufficient measures to ensure quality patient care. Of the hospices with deficiencies cited during complaint investigations, 49 percent had already been cited for the same deficiencies during the regular certification surveys. Based on our findings, we recommended that CMS provide guidance to State agencies and CMS regional offices regarding analysis of existing data and identification of at-risk hospices, include hospices in Federal comparative surveys and annual State performance reviews, and seek legislation to establish additional enforcement remedies for poor hospice performance. At present, CMS's only enforcement remedy is termination of hospices from the Medicare program. CMS indicated that it is exploring and implementing methods to better target hospices in need of closer oversight. CMS is also considering whether to pursue new enforcement requirements for poor hospice performance. However, citing budget constraints, CMS indicated that it does not plan to include hospices in the annual State performance reviews.

Screening of Long-Term Care Employees

Residents of nursing homes and other long-term-care facilities have a right to reside in a safe and secure environment, free from abuse and neglect. To help achieve this type of environment, each State is required to establish and maintain a registry of nurse aides, which includes information on any finding by the State survey and certification agency of abuse, neglect, or misappropriation of property involving the elderly. CMS prohibits facilities from employing individuals who have been found guilty by a court of law or who have had a finding entered into the registry for abuse, neglect, or mistreatment of residents or misappropriation of their property.

In several recent reviews, OIG found that States and nursing facilities use a patchwork of measures to identify persons posing a possible threat of elder abuse in nursing homes and to minimize and prevent such abuse. For example, in a July 2005 report, we found that although most facilities check their State nurse aide registries prior to employing an individual, they do not routinely check those in other States, thereby potentially jeopardizing the safety of their residents. Additionally, while most States require criminal background checks, the scope of these checks varies widely. We also found that although some of the nursing facilities in our sample conducted more comprehensive checks than required by their State laws, about half of the background checks done were limited in scope, e.g., limited to one State.

In another review, issued February 2005, that examined the accuracy of nurse aide registries maintained by States, OIG found that some States failed to adequately update registries with information on substantiated adverse findings against nurse aides. In fact, some individuals with criminal records in one State were actively certified in other States.

Without accurate nurse aide registry information, nursing homes may inadvertently hire aides who have committed offenses such as abuse, neglect, and theft, thus placing residents at considerable risk. Therefore, we recommended that CMS ensure that records of nurse aides with substantiated adverse findings are updated timely and work with States to ensure that registry records contain current information on nurse aides.

In a December 2006 report, OIG reviewed the requirements for, and State oversight of, Medicaid personal care service attendants. These attendants assist the elderly and persons with disabilities or temporary or chronic conditions with daily activities (e.g., bathing, dressing, meal preparation). This review found substantial variation, both across States and within States, in the requirements for these attendants and found that oversight and administration of personal care programs were fragmented.

In testimony before this committee in 1998, we recommended stronger Federal oversight, as well as stepped-up collaboration with the States, to improve the safety of the elderly. Specifically we recommended that CMS and the Administration on Aging (1) consider establishing Federal requirements and criteria for performing criminal background checks of all workers in nursing homes and other long-term care facilities and (2) assist in the development of a national abuse registry and expansion of the current State registries to include all workers who have abused or neglected residents or misappropriated resident property in facilities that receive Federal reimbursement. Our updated work continues to demonstrate that there is no nationwide assurance that nursing home staff who could place elderly residents at risk are systematically identified and excluded from employment. Therefore, to reduce the potential for nurse aides with substantiated findings to commit similar acts in another State, we again suggested in our 2005 reports that CMS could seek legislative authority to create a national nurse aide registry and recommended that CMS consider developing a Federal requirement for criminal background checks.

Impact of Reimbursement Systems on Access and Quality of Care

In recent years, OIG has also monitored the potential impact of various Medicare and Medicaid payment systems on the provision of services in inpatient hospitals, nursing homes, and home health agencies. For example, in reports issued in July 2006, we examined beneficiary access to home health and skilled nursing facility care since the implementation of the prospective payment system and found that, although the vast majority of Medicare beneficiaries have access to care, some with certain medical conditions, such as those needing IV antibiotics and/or expensive drugs and those with complex wound care needs, may experience delays in obtaining necessary care. In another report issued in 2006, we examined the hospital readmission and emergency department visit rates for Medicare beneficiaries discharged from hospitals to home health care to determine whether the rates have changed since the implementation of the home health prospective payment system in 2000. We suggested that CMS closely monitor beneficiaries with particular health care needs most associated with problems in access and cases in which there is a greater likelihood of hospital readmission or emergency care.

Most recently, in a report issued last month, we assessed services provided to beneficiaries with consecutive Medicare stays involving inpatient and skilled nursing facilities and found that 35 percent of consecutive stay sequences were associated with quality-of-care problems and/or fragmentation of services for which Medicare paid an estimated \$4.5 billion. Quality-of-care problems that reviewers found included medical errors, accidents, failure to treat patients in a timely manner, inadequate monitoring and treatment of patients, inadequate care planning, and inappropriate discharges. We recommended that CMS (1) direct Quality Improvement Organizations (QIO) to monitor fragmentation and quality of care across consecutive stay sequences and the quality of care provided during the individual stays within those sequences and (2) encourage both QIOs and fiscal intermediaries, as appropriate, to monitor the medical necessity and appropriateness of services provided within these consecutive stay sequences. CMS concurred with our recommendations and indicated that it intends to place a greater emphasis on continuity of care in all settings and on measuring the rate of adverse events, such as hospital readmissions.

OIG is also concerned about whether payments to nursing homes are correct and whether the funds are being used for patient-care-related activities. For example, in a series of audits issued in 2004 and 2005, we examined the adequacy of Medicaid payments to nursing facilities in States that have enhanced payment programs for public nursing facilities. As part of these studies, OIG determined that Medicaid reimbursements to States for nursing home care are being diverted from the nursing homes to other State programs. To illustrate, OIG examined nursing homes from each of three States (New York, Tennessee, and Washington) and found that these nursing homes were required by their State or county to return 90, 96, and 94 percent, respectively, of their enhanced funding. These nursing homes had received the most unfavorable survey ratings the States can issue. These homes might have provided better quality of care had they been able to retain all the funding they initially received.

OIG INVESTIGATIONS AND ENFORCEMENT

Although OIG investigates cases of significant abuse or neglect and takes appropriate administrative actions, CMS and the States bear the primary responsibility for regulating and policing the quality of health care provided to patients as well as referring appropriate cases to law enforcement. CMS issues regulations and program guidance that set the requirements for quality of care in entities participating in Federal health care programs. And, as previously described, CMS and the States coordinate to conduct surveys and review providers under the certification process. When deficiencies are identified, CMS may take enforcement actions, such as imposition of CMPs, denial of payment for new admissions, and termination. In addition, State licensing boards for physicians, nurses, and other health professionals (including nursing home administrators) revoke or suspend the health care licenses of many individuals for poor care or patient abuse. Finally, through Medicaid Fraud Control Units (MFCU), States investigate and prosecute individuals and entities for patient abuse, as well as fraud.

To supplement or, when appropriate, substitute for CMS or State enforcement actions, OIG pursues administrative remedies, often in conjunction with civil actions brought by the Department of Justice (DOJ). The False Claims Act, the Federal Government's primary civil enforcement tool for fraud, has been used successfully to address poor quality of care. In addition, OIG has exercised its administrative authorities in these cases to exclude providers from participation in Federal health care programs and to impose substantial compliance requirements and monitoring on those providers that continue to participate. This combination of civil and administrative enforcement actions has effectively complemented the administrative and regulatory oversight by CMS and the States and criminal prosecutions by the States.

Civil and Criminal Actions and Law Enforcement Coordination

OIG partners with DOJ, MFCUs, and other state law enforcement offices to investigate and prosecute instances of substandard care that led to patient harm. Under the False Claims Act, the Government is authorized to collect substantial penalties against anyone who has knowingly caused the submission of false or fraudulent claims to the Federal Government. DOJ is responsible for representing the United States in these civil cases, which often involve allegations that claims to Medicare or Medicaid are false because they misrepresent the services that have been provided to beneficiaries. Over the past decade, DOJ has successfully pursued False Claims Act cases under the theory that egregiously substandard care is a "failure of care" and that claims for such care are fraudulent. Medicare and Medicaid cover only costs that are reasonable and necessary for the diagnosis or treatment of illness or injury. The provision of medically unnecessary or substandard care exposes patients to health risks and imposes needless expenses on the Federal health care programs.

The Government has pursued this civil cause of action only in cases that involve systemic and widespread problems of quality or significant harm to patients. For example, United Memorial Hospital in Michigan pleaded guilty in Federal court to wire fraud based on its failure to properly investigate medically unnecessary pain management procedures performed by a physician on its medical staff. In another case, Redding Medical Center in California and its corporate parent, Tenet Healthcare Corporation, paid a total of \$59.5 million to settle False Claims Act allegations that the hospital inadequately performed credentialing and peer review of cardiologists on its staff who then performed medically unnecessary invasive cardiac procedures.

In another example, the Government settled a False Claims Act case with Life Care of Lawrenceville, a Georgia nursing home, for \$2.5 million. The Government alleged poor care in the following areas: (1) diabetes care, (2) resident nutrition and hydration, (3) assessments and evaluations of residents' needs, (4) care planning and nursing interventions, (5) medication management, (6) fall prevention and management, and (7) pressure ulcer care. Many of the problems were related to chronic understaffing. Among the examples of poor care alleged by the Government, a resident on coumadin medication died of toxic poisoning because the facility staff failed to check his blood levels. Another resident allegedly fell four times during her 4-month stay and fractured

and refractured her hip. Still another resident allegedly developed maggots in her mouth and died of larvae infestation because the facility staff failed to provide basic oral hygiene care.

Federal prosecutors in Missouri charged American Healthcare Management (AHM), a long-term care facility management company, its Chief Executive Officer, and three nursing homes with criminal conspiracy and health care fraud based on their imposition of budgetary constraints that prevented the facilities from providing adequate care to residents. The investigation found that numerous residents suffered from dehydration and malnutrition, went for extended periods of time without cleaning or bathing, and contracted preventable pressure sores. The corporate defendants were convicted and fined, entered into a False Claims Act settlement of \$1.25 million, and agreed to be excluded. The primary owner was convicted of a false statement misdemeanor offense, sentenced to 2 months' incarceration, and agreed to be excluded for 20 years. Finally, in February 2007, AHM's former CEO was sentenced to 18 months of incarceration and fined \$29,000.

In addition to our close collaboration with DOJ on these Federal cases, since the enactment of the Deficit Reduction Act of 2005, OIG has increased coordination with MFCUs, with particular focus on quality of care investigations. As part of these efforts, OIG organized a September 2006 national training conference with representatives from MFCUs, State Medicaid agencies, and DOJ. Since that time, OIG has continued this collaboration in regional conferences with MFCU and OIG investigators focusing on how to identify and build quality of care cases.

Exclusions

In addition to the administrative sanctions available to CMS and the States and the criminal and civil tools available to the States and DOJ, OIG often utilizes its administrative exclusion authority to address poor quality of care. Once a person is excluded, Federal health care programs will not pay for items or services furnished by that person. Exclusions related to quality of care arise in the following situations:

- OIG must exclude any person convicted of an offense related to the abuse or neglect of a patient in connection with the delivery of health care (Section 1128(a)(2) of the Social Security Act).
- OIG may exclude any person whose license to practice health care has been revoked or suspended for reasons bearing on the person's professional competence or professional performance (Section 1128(b)(4) of the Social Security Act).
- OIG may exclude any person who has furnished items or services to patients: (1) substantially in excess of the needs of such patients or (2) that fail to meet professionally recognized standards of care (Section 1128(b)(6)(B) of the Social Security Act).

- Based on the referral of a QIO, OIG may exclude a physician or other practitioner for failing to comply with the obligations to provide Medicare beneficiaries only medically necessary services that meet professionally recognized standards of care (Section 1156 of the Social Security Act).
- OIG may exclude anyone who has caused the submission of false or fraudulent claims to a Federal health care program (Section 1128(b)(7) of the Social Security Act). This provision parallels the False Claims Act and is implicated in any case in which the Government is asserting a failure-of-care theory in a civil case.

The exclusion actions described above fall under two broad categories: (1) derivative (based on an action by another Government agency or tribunal) and (2) affirmative (initiated independently by OIG). OIG has exercised all of these exclusion authorities to build upon and supplement enforcement actions taken by States, CMS, and DOJ. To provide protection to Federal health care program beneficiaries, OIG imposes derivative exclusions of persons who have been convicted of patient abuse or neglect or who have lost medical, nursing, or other health care licenses for reasons related to abuse or neglect of patients or professional competence. In fiscal year 2006, OIG excluded 295 persons based on convictions of patient abuse or neglect and 1,867 persons based on revocation or loss of a health care license.

In addition to imposing these large numbers of derivative exclusions, OIG initiates affirmative exclusions to strategically address serious quality-of-care concerns that have not been addressed through other enforcement actions. And, just as we exclude direct caregivers who pose a risk to patients, OIG investigates the owners and managers who are responsible for allowing the abuse of patients or provision of substandard care, as well as entities that have demonstrable, systemic poor quality of care. For example, OIG excluded a nursing home owner for causing the provision of substandard care in his facilities as a result of providing insufficient staffing and financial support. Because, the owner was not a licensed health care professional (or nursing home administrator), the exclusion was the best remedy to bar him from involvement in Federal health care programs. In another example, OIG initiated proceedings to exclude Redding Medical Center for conduct that resulted in the \$59.5 million False Claims Act recovery. As described earlier, the Government found a pattern of inappropriate and medically unnecessary invasive heart procedures and a lack of appropriate controls to detect and address such problems. To resolve OIG's exclusion case, Tenet divested the hospital to a new owner/operator.

Corporate Integrity Agreements

As part of the resolution of False Claims Act cases, OIG often agrees to not exclude a defendant in exchange for the defendant entering into a corporate integrity agreement (CIA) with OIG. A CIA is a contract that imposes systems, monitoring, and reporting requirements on providers. A CIA generally requires the entity to employ a compliance officer, establish a compliance committee, implement a code of conduct and policies and procedures, train staff, establish internal reporting mechanisms for compliance issues,

report and repay overpayments, screen employees and contractors to prevent hiring of excluded persons, report and remedy probable violations of law, and hire an independent review organization to review claims submitted to Federal health care programs. The entity must also report to OIG annually and when certain significant events occur. If the entity fails to comply with the CIA, OIG may impose stipulated monetary penalties and, for substantial material breaches, exclusion. OIG currently monitors about 350 health care entities of all types operating under CIAs.

In CIAs arising from failure of care cases, OIG has also required the providers, often nursing home chains, to hire independent quality monitors selected by OIG. These quality-of-care CIAs place particular emphasis on the provider's policies and systems that affect the quality of care provided to individual patients. Under these CIAs, the monitors have extensive access to facilities, staff, patients, and records. Using that access, survey results, and other quality-related data, the monitors identify quality problems and, in consultation with the provider, recommend enhancements to systems and controls to improve the quality of care. The independent monitors effectively build upon and complement the actions of surveyors, who are necessarily focused on specific incidents at specific facilities. By examining and consulting on systems improvements and controls throughout an organization, quality-of-care CIAs help create an environment that promotes better care throughout a provider, whether it is a single site or a national chain.

Over the last 7 years, many major nursing home chains, smaller groups, and individual health care facilities have operated under CIAs with independent quality monitors. Since 2002, over 1,300 health care facilities, mostly nursing homes, have operated for some period of time under a quality-of-care CIA. OIG currently has 10 CIAs with nursing homes and psychiatric facilities (or chains) with independent quality monitor requirements. These 10 active quality-of-care CIAs cover operations in about 400 long-term care and psychiatric facilities across the country. In addition to conducting our ongoing monitoring efforts, OIG is examining the performance of nursing home chains operating under CIAs over the past several years to evaluate the effect of those CIAs on the quality of care and compliance by those chains.

COMPLIANCE GUIDANCE AND RESOURCES

In addition to conducting enforcement activities, OIG provides nonbinding guidance to providers regarding how to establish systems and controls to promote and monitor compliance with Federal health care program requirements. Much of this voluntary guidance focuses on the importance of providing high quality health care to patients. For example, in the "Compliance Program Guidance for Nursing Facilities," OIG identified quality of care as the first major risk area and outlined specific examples of circumstances that raised significant compliance concerns. This guidance next outlined the importance of safeguarding residents' rights. As part of our ongoing review of existing guidance in light of current concerns, OIG plans to begin the process of proposing and issuing an updated guidance for nursing facilities that will focus even

more on quality-of-care issues. These compliance guidance documents provide concrete information that can be applied by a provider's management to its own circumstances.

OIG has more recently increased its focus on the role of boards of directors or trustees in promoting and overseeing compliance and quality of care at health care providers. It is essential that members of boards of health care providers focus at least as much attention on the quality of care furnished by the provider as on financial performance. Like direct caregivers, those responsible for overseeing a health care provider have an obligation to safeguard patients and ensure the resources and conditions are present to allow for the provision of high quality care. Last month, OIG issued a resource document for board members of health care providers, "Corporate Responsibility and Health Care Quality: A Resource for Health Care Boards of Directors." This document, developed jointly with leaders in the American Health Lawyers Association, outlines the relevant background and principles that apply to a board member's responsibility to oversee the quality of care furnished by a health care provider. The resource document suggests questions that a board member may want to ask as part of his or her inquiry into the organization's quality safeguards. These questions focus on the quality improvement infrastructure, leadership, policies and procedures, performance metrics, risk assessment, reporting mechanisms, resources, peer review and credentialing, and the handling of adverse patient events.

OIG plans to build on this recently issued resource document through holding a future roundtable discussion including representatives from the long-term care industry, OIG, and other stakeholders. This roundtable will explore the reasons that providing good quality of care is not only the right thing to do for the benefit of the patients but is also in the long-term interests of the provider. One goal of this roundtable will be to generate practical, concrete ideas regarding how board members can receive useful information about quality to fulfill their oversight role. One concept we plan to explore in this roundtable is guidance on how to construct a "dashboard" that would allow board members (and management) to monitor a discrete set of indices that reflect on the quality of care provided by the organization. After reviewing the results of this roundtable examining long-term care facilities, we hope to initiate a similar dialogue with representatives of the hospital industry and other provider groups. These efforts should raise board and management awareness of the importance of quality care as well as provide practical guidance to those individuals in positions of authority about how they can monitor and improve the quality of care.

CONCLUSION

Today I have described some egregious examples of abuse and neglect of the elderly, with the results ranging from dehydration and malnutrition to the provision of unnecessary heart surgery. I have also described our extensive work examining the oversight and enforcement systems designed to identify and prevent the continuation of abuse in a variety of health care settings, and our work with our law enforcement partners to investigate and sanction cases of abuse or neglect.

We are continuing to evaluate systemic issues that directly affect patient care. For example, studies are currently underway to examine the cyclical noncompliance of home health agencies with conditions of participation, the use of psychotherapy services in nursing homes, payments and care for hospice beneficiaries residing in nursing homes, the oversight of quality of care in Federal health centers, and the impact of Medicare Part D on dual eligible residents in nursing homes. OIG is also undertaking a congressionally mandated review of serious medical errors, referred to as “never events,” because they should never occur, for example, a physician performing surgery on the wrong patient.

OIG will continue to work collaboratively with our Federal and State law enforcement partners to investigate and sanction those responsible for egregiously substandard care. In addition to direct care-givers, OIG will also hold managers and decision-makers accountable when beneficiaries are harmed as a consequence of placing financial interests over clinical needs. Because of the vulnerability of nursing home residents, we will continue our focus on quality of care in these facilities. As we look forward, we expect to expand our focus on quality of care to other types of facilities serving the elderly that are funded through the Federal health care programs, including Intermediate Care Facilities for People with Developmental Disabilities and Institutions for Mental Disease.

We recognize that these oversight mechanisms and enforcement actions are designed to identify and address quality-of-care problems after they have already occurred. Therefore, OIG is committed to working with stakeholders including Congress and industry representatives to identify practices that will help prevent these types of abuses from occurring. For instance, we have recommended establishing a national nurse aide registry and requiring long-term care facilities to conduct criminal background checks, steps that would help to ensure that this Nation’s elderly are not exposed to those who would take advantage of their vulnerabilities.

In the next step of our ongoing efforts to provide guidance to the health care providers, we will build upon our recently issued resource document and engage in a dialogue with stakeholders about quality measures and how board members can effectively oversee the quality of care provided by their health care organizations. The guidance that arises from this process, as well as from the updating of our compliance program guidance for nursing facilities, will provide practical information about how leaders of health care providers can implement the systems, policies, and controls that will improve the quality of care and reduce the risk of abuse of patients.

This concludes my statement. Thank you for the opportunity to testify today.

At this time, I would be happy to answer any questions you may have.

Selected Reports and Resources
U.S. Department of Health and Human Services
Office of Inspector General

Consecutive Medicare Stays Involving Inpatient and Skilled Nursing Facilities (OEI-07-05-00340; June 2007) <http://oig.hhs.gov/oei/reports/oei-07-06-00340.pdf>

Corporate Responsibility and Health Care Quality: A Resource for Health Care Boards of Directors, June 2007
<http://oig.hhs.gov/fraud/docs/complianceguidance/Corporate%20Responsibility%20and%20Health%20Care%20Quality%206-29-07.pdf>

Medicare Hospices: Certification and Centers for Medicare & Medicaid Services Oversight (OEI-06-05-00260; April 2007) <http://oig.hhs.gov/oei/reports/oei-06-05-00260.pdf>

States' Provider Safeguards for Medicaid Personal Care Services (OEI-07-05-00250; December 2006) <http://oig.hhs.gov/oei/reports/oei-07-05-00250.pdf>

Nursing Home Complaint Investigations (OEI-01-04-00340; July 2006)
<http://oig.hhs.gov/oei/reports/oei-01-04-00340.pdf>

Beneficiary Access to Home Health Agencies (OEI-02-04-00260; July 2006)
<http://oig.hhs.gov/oei/reports/oei-02-04-00260.pdf>

Medicare Beneficiary Access to Skilled Nursing Facilities Under the Prospective Payment System (OEI-02-04-00270; July 2006) <http://oig.hhs.gov/oei/reports/oei-02-04-00270.pdf>

Nursing Home Enforcement: Application of Mandatory Remedies (OEI-06-03-00410; May 2006) <http://oig.hhs.gov/oei/reports/oei-06-03-00410.pdf>

Effect of the Home Health Prospective Payment System on the Quality of Home Health Care (OEI-01-04-00160; February 2006) <http://oig.hhs.gov/oei/reports/oei-01-04-00160.pdf>

Nurse Aide Registries: Long Term Care Facility Compliance and Practices (OEI-07-04-00140; July 2005) <http://oig.hhs.gov/oei/reports/oei-07-04-00140.pdf>

Adequacy of New York State's Medicaid Payments to A. Holly Patterson Extended Care Facility (A-02-03-01004; April 2005)

<http://oig.hhs.gov/oas/reports/region2/20301004.pdf>

Nursing Homes Enforcement: The Use of Civil Money Penalties (OEI-06-02-00720; April 2005) <http://oig.hhs.gov/oei/reports/oei-06-02-00720.pdf>

Adequacy of Tennessee's Medicaid Payments to Nashville Metropolitan Bordeaux Hospital, Long-Term-Care Unit (A-04-03-03023; April 2005)

<http://oig.hhs.gov/oas/reports/region4/40303023.pdf>

Adequacy of Washington State's Medicaid Payments to Newport Community Hospital, Long-Term-Care Unit (A-10-04-00001; March 2005)

<http://oig.hhs.gov/oas/reports/region10/100400001.pdf>

Nurse Aide Registries: State Compliance and Practices (OEI-07-03-00380; February 2005) <http://oig.hhs.gov/oei/reports/oei-07-03-00380.pdf>

Adequacy of Medicaid Payments to Albany County Nursing Home (A-02-02-01020; June 2004) <http://oig.hhs.gov/oas/reports/region2/20201020.pdf>

Nursing Home Deficiency Trends and Survey and Certification Process Consistency (OEI-02-01-00600; March 2003) <http://oig.hhs.gov/oei/reports/oei-02-01-00600.pdf>

[Final Compliance Program Guidance for Nursing Facilities](http://oig.hhs.gov/authorities/docs/cpgnf.pdf) (65 FR 14289; March 16, 2000) <http://oig.hhs.gov/authorities/docs/cpgnf.pdf>