United States Senate
COMMITTEE ON FINANCE
WASHINGTON, DC 20510–6200

September 15, 2017

The Honorable Thomas E. Price, M.D.
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Secretary Price,

I write regarding the Department of Health and Human Services Office of Inspector General's (the OIG) August 24, 2017 "Early Alert" concerning potential abuse or neglect of Medicare beneficiaries in federally funded skilled nursing facilities (SNF). As Chairman of the Senate Finance Committee, I have the responsibility to oversee the Medicaid and Medicare programs and am troubled by these allegations. As such, I hope that we can work together towards a solution to protect seniors and prevent future occurrences of abuse or neglect.

Section 6703(b)(3) of the Affordable Care Act amended Title XI by adding Section 1150B, requiring covered individuals working at a long-term care facility receiving over $10,000 in Federal funds to report "any reasonable suspicion of a crime" committed against a resident of, or an individual receiving care from, the facility. Reports must be submitted to at least one law enforcement agency of jurisdiction and a Survey Agency.

In 2016, there were a total of 16,756 SNFs nationwide. As part of its ongoing investigation, the OIG audited these SNFs and compared Medicare claims for reimbursement of emergency room services with claims submitted for the treatment of Medicare beneficiaries residing at SNFs. The OIG identified 134 Medicare beneficiaries whose injuries may have been the result of potential abuse or neglect between January 1, 2015 and December 31, 2016. According to the records reviewed by the OIG, 96 of the 134 incidents were reported to the authorities. However, there was no evidence that the remaining 38 incidences were reported despite mandatory reporting requirements. Based on these results and prior reports, the OIG is concerned that incidents of abuse or neglect at SNFs go unreported.

Based on its findings thus far, the OIG recommended that CMS implement procedures to compare Medicare claims for emergency room treatment with claims for SNF services to identify incidents of abuse or neglect. Additionally, the OIG recommended that CMS work with HHS to receive authority to impose civil monetary penalties and exclusion provisions as provided by Section 1150B of the Act.

To help the Committee evaluate possible actions that can assist the agency in identifying instances of elder abuse or neglect, we ask that HHS provide the following information:

1. In light of this alert, does HHS or any of its agencies plan to reevaluate its procedures to ensure that elder abuse or neglect in long-term care facilities is identified and reported? If so, please describe this work.

2. According to the OIG, Centers for Medicare & Medicaid (CMS) officials have not taken any enforcement actions regarding 1150B because the HHS Office of the Secretary has not delegated the enforcement of this section to CMS. When will HHS delegate authority to CMS? If so, when? If not, why not?

3. In regards to the 38 incidents not reported to local law enforcement, does HHS plan to take enforcement actions against either the covered individual and/or the long-term care facility? If so, please explain.

4. What efforts would you recommend Congress consider to assist the agency and law enforcement officials prevent elder abuse and neglect in federally-funded long term care facilities?

Thank you in advance for your cooperation with this request. Please provide your response to the above questions by October 6, 2017. If you have any questions, please contact [redacted]

Sincerely,

Orrin G. Hatch
Chairman