

GAO

Report to the Chairman and Ranking
Minority Member, Special Committee on
Aging, U.S. Senate

March 1999

NURSING HOMES

Complaint Investigation Processes Often Inadequate to Protect Residents



Printed copies of this document will be available shortly.



United States
General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

B-281767

March 22, 1999

The Honorable Charles E. Grassley
Chairman
The Honorable John B. Breaux
Ranking Minority Member
Special Committee on Aging
United States Senate

The 1.6 million elderly and disabled residents confined to nursing homes are a highly vulnerable population. They are frequently dependent on extensive assistance in basic activities of daily living like dressing, grooming, feeding, and using the bathroom, and many require skilled nursing or rehabilitative care. The vast majority of nursing homes participate in Medicare and Medicaid and are expected to receive nearly \$39 billion in federal payments from these programs in 1999. For these nursing homes, providing adequate care is a federal mandate backed by about \$210 million in federal funding going to state agencies that inspect and certify nursing homes' compliance with quality standards through annual surveys and complaint investigations. About \$42 million of this goes to fund investigations of complaints that are lodged by various sources, including residents, their families, and nursing home employees, and incidents of potential abuse or neglect that nursing homes report to states.

In our July 1998 report to you, we found that unacceptable care was a problem in many California nursing homes, including one in three where state surveyors identified serious or potentially life-threatening care problems. We also reported that federal and state oversight is not sufficient to guarantee the safety and welfare of nursing home residents.¹ In a companion report issued last week, we further found that current federal enforcement efforts cannot ensure sustained compliance with federal standards for nursing home care.²

Concerned that annual surveys alone are inadequate to meet the federal goal of ensuring nursing home residents' health and safety, you asked us to examine how states implement the federal requirement that states establish a process for nursing home complaint investigations. Complaint investigations offer a unique opportunity to identify and correct potential care problems because they can provide a more timely alert than annual inspections, and they target specific areas of potential problems identified by residents, their families, the concerned public, and even the facility itself. Specifically, this report assesses

¹California Nursing Homes: Care Problems Persist Despite Federal and State Oversight (GAO/HEHS-98-202, July 27, 1998).

²Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards (GAO/HEHS-99-46, Mar. 18, 1999).

the effectiveness of (1) state complaint investigation practices as a component of the system to ensure sustained compliance with federal nursing home quality-of-care standards and (2) the Health Care Financing Administration's (HCFA) role in establishing standards and conducting oversight of states' complaint investigation practices and in using information about the results of complaint investigations to ensure compliance with nursing home standards. We assessed complaint investigation practices in Maryland, Michigan, and Washington State; reviewed state auditors' reports from 11 other states;³ and examined HCFA's policies and procedures for overseeing state complaint investigation activities. Appendix I provides more details about our scope and methodology.

Results in Brief

Federal and states' practices for investigating complaints about care provided in nursing homes are often not as effective as they should be. Among many of the 14 states we examined, we found numerous problems, including

- procedures or practices that may limit the filing of complaints,
- understatement of the seriousness of complaints, and
- failure to investigate serious complaints promptly.

Serious complaints alleging that nursing home residents are being harmed can remain uninvestigated for weeks or months. Such delays can prolong situations in which residents may be subject to abuse, neglect resulting in serious care problems like malnutrition and dehydration, preventable accidents, and medication errors.

Although federal funds finance over 70 percent of complaint investigations nationwide, HCFA plays a minimal role in providing states with direction and oversight regarding these investigations. HCFA has left it largely to the states to decide which complaints potentially place residents in immediate jeopardy and must be investigated within the federally mandated 2 workdays. If a serious complaint that could harm residents is not classified as potentially placing residents in immediate jeopardy, there is no formal requirement for prompt investigation. More generally, HCFA's oversight of state agencies that certify federally qualified nursing homes has not focused on complaint investigations. We found that

- a HCFA initiative to strengthen federal requirements for complaint investigations was discontinued in 1995, and resulting guidance developed for states' optional use has not been widely adopted;
- federal reviews of state nursing home inspections are primarily intended to focus on the

³The state reports examined Iowa, Kansas, Kentucky, Louisiana, New York, North Carolina, Ohio, Pennsylvania, Tennessee, Texas, and Wisconsin. These reports were produced by either the state auditor or similar organizations, such as the Office of Inspector General. In this report, we refer to these reports as state auditor reports.

annual surveys of nursing homes, and very few reviews are conducted of complaint investigations;

- since 1998, HCFA has required state agencies to develop their own performance measures and quality improvement plans for their complaint investigations, but for several of the 14 states we reviewed, such assessments addressed complaint processes superficially or not at all; and
- HCFA reporting systems for nursing homes' compliance history and complaint investigations do not collect timely, consistent, and complete information.

We are recommending stronger federal requirements for states to promptly investigate serious complaints alleging situations that may harm residents but are not classified as immediate jeopardy, increased federal monitoring of states' performance in responding to complaints, and improved tracking of the substantiated findings of complaint investigations. Such steps can strengthen the ability of federal and state regulators to use complaint investigations to protect and improve the care nursing home residents receive.

Background

Nearly all nursing homes accept residents with either Medicare or Medicaid and are projected to receive nearly \$39 billion in federal payments from these programs in 1999. The federal government, through HCFA, has responsibility for establishing requirements that nursing homes must meet to participate in the Medicare and Medicaid programs and ensuring that these standards are met. HCFA carries out this responsibility by contracting with states to monitor nursing homes. As part of these contracts, the states agree to comply with regulations and other general instructions that HCFA prescribes.

The Omnibus Budget Reconciliation Act of 1987 revised the standards for homes' participation in these federal programs and defined federal and state roles for ensuring that nursing homes meet these standards. In this regulatory framework, states (1) license nursing homes to do business in the state, (2) certify to the federal government, by conducting reviews of nursing homes, that homes are eligible for Medicare and Medicaid payment, and (3) investigate complaints about care provided in the homes. As part of their oversight, the states are required to conduct annual surveys of homes. While the annual surveys seek to provide a nationally uniform process to evaluate whether nursing homes meet a comprehensive range of federal standards, they are often predictable in their timing.⁴ Complaint investigations can be less predictable than annual surveys and generally provide a unique opportunity for more frequent state inspections that assess conditions at the nursing home while focusing on specific concerns raised by residents, their families, or other observers. HCFA oversees states' performance by monitoring at least 5 percent of states' surveys and by requiring states to develop a quality improvement program that incorporates

⁴HCFA has recently initiated efforts intended to reduce the predictability of the timing of annual surveys, such as doing some during evenings or weekends.

performance goals and measures in seven required core performance areas—including complaint investigations—and other optional state-identified areas.⁵

In addition to the requirement that states establish a complaint investigation process, HCFA requires that states investigate the most serious complaints that allege situations immediately jeopardizing the health or safety of residents within 2 workdays, but leaves the timing, scope, duration, and conduct of other complaint investigations to the discretion of the state survey agency. Thus, states establish their own priorities and time frames for investigating complaints that they determine do not represent immediate jeopardy to resident health and safety. In addition, states require nursing homes to report and investigate incidents such as injuries that might signal neglect or abuse. The state then determines whether it will further investigate the incident.

When states conduct a complaint investigation, they attempt to substantiate whether the allegations are valid. If a complaint is substantiated, the state may cite the nursing home for violating either federal or state standards. In such cases, the state agency will require the home to develop an approved plan of correction. The state may choose to take action under the state's licensing authority, using applicable state remedies and sanctions. If the deficiency relates to federal standards, information regarding the deficiency is also to be reported to HCFA. Serious deficiencies require that the home attain compliance within a set time frame or face enforcement sanctions, such as civil monetary penalties, by HCFA or the state.

Both federal and state funds finance the costs state agencies incur in inspecting nursing homes and investigating complaints. In 1998, the federal government paid states about \$210 million for the nursing home survey and certification process, including about \$42 million (20 percent) for investigating complaints. States contributed an additional \$17 million for complaint investigations. On average, federal funds account for 71 percent of states' complaint investigation expenditures. Table 1 compares these expenditures for the states visited. Appendix II includes additional expenditure information for all states and further discusses the allocation of federal and state shares. Generally, the federal government finances states' complaint investigation costs for nursing homes in the same proportion that it finances annual and other surveys.

⁵A forthcoming GAO report will examine federal oversight of state agencies' nursing home certification activities, including the federal monitoring surveys and the State Agency Quality Improvement Program.

Table 1: Federal and State Expenditures for Complaint Investigations, 1998

	Total expenditures for complaint investigations	Percentage of total survey and certification expenditures	Percentage of total expenditures federally funded	Average expenditures per on-site investigation	Average expenditures per home
Maryland	\$ 232,666	8	60	\$1,199	\$885
Michigan	1,204,179	16	71	1,361	2,694
Washington	2,156,161	30	59	664	7,592
U.S. total	\$58,833,689	20	71	\$1,430	\$3,397

Some States' Complaint Practices Are Limited in Protecting Nursing Home Residents

Although investigations of complaints filed against nursing homes can provide a valuable opportunity for determining whether the health and safety of residents are threatened, complaint investigation practices do not consistently achieve this goal. Some states use procedures that may discourage the public from filing complaints. Furthermore, some states fail to recognize and promptly respond to complaints that may pose immediate jeopardy to a resident's health, safety, or life. Likewise, some states do not require that other serious complaints, including those that allege harm to residents, be investigated for months after the complaint's receipt. Additionally, many complaints are not investigated within states' required time frames for conducting an investigation. Consequently, we found several instances in which, after an extended delay, the complaint investigators substantiated that residents had been harmed and other cases in which the state was unable to determine whether the allegations were true partly because so much time had elapsed since the complaint was received.

Procedures and Practices May Limit the Public's Filing of Complaints

Because nursing home residents and the public need an effective and expedient means to seek correction of problems that they perceive endanger the health and safety of nursing home residents, the process of filing a complaint should not place an unnecessary burden on the complainant. Nevertheless, some states we reviewed have procedures or practices that may limit the number of complaints. For example, when a person calls with a complaint, Maryland and Michigan encourage him or her to submit the complaint in writing.

- Michigan requires that either complainants write a complaint or the state will provide

assistance in writing the complaint. About 95 percent of publicly reported⁶ complaints were submitted in writing between July 1997 and June 1998.

- Maryland's policy is to accept and act on a complaint by phone even though callers are encouraged to submit a written complaint. However, state officials provided us conflicting information as to whether calls would be consistently documented and investigated when callers agreed to submit a written complaint but did not do so. Over 70 percent of Maryland's publicly reported complaints that the state investigated were identified as written complaints between July 1997 and June 1998.⁷
- In contrast, Washington readily accepts complaints by phone and nearly all complaints are received by phone. This contributes to Washington receiving a considerably higher number of complaints than Michigan or Maryland.

See table 2 for a comparison of the total number of nursing home complaints received in a year by these states.

Table 2: Complaints Received Between July 1, 1997, and June 30, 1998

	Number of complaints received	Number of complaints per 1,000 nursing home beds
Maryland	642	21
Michigan	2,243	45
Washington	8,748	336

States Establish Widely Varying Categories for Prioritizing Complaints

When a complaint is received, the state agency ascertains its potential seriousness. HCFA requires that complaints that may involve immediate jeopardy of a resident's health, safety, or life be investigated by states within 2 workdays of receipt.⁸ For other complaints, states are permitted to establish their own categories and time frames for investigation. States have established varying time requirements for complaint responses and varying criteria for prioritizing these complaints, including criteria for complaints that may involve a significant risk of actual harm to nursing home residents. Some states permit relatively long periods of time to pass between the receipt of all such complaints and their investigation. For example, for complaints that may involve significant risk of actual harm to residents,

- Michigan's statute allows 30 days, but in 1998 Michigan's operating practice was to allow

⁶In this report, publicly reported complaints are those from residents, family, or friends.

⁷The percentage is based on the total number of complaints that have information about whether the complaint was in writing or by telephone.

⁸Some states have a more stringent requirement than the federal requirement. For example, Michigan, Louisiana, and Kansas require immediate jeopardy complaints to be investigated within 24 hours.

45 days;

- Tennessee allows 60 days; and,
- Kansas allows 180 days.

Some states have established other priority categories with similar time frame classifications, but their criteria for determining which complaints to include in these classifications differ substantially. Maryland and Washington both have classification schemes that include categories for complaints to be investigated within 2, 10, or 45 workdays or at the next on-site investigation.⁹ Similarly, Pennsylvania classifies complaints to be investigated within 2, 5, 10, or 45 workdays or at the next on-site survey. Criteria for complaints to be included in the 10-day category for Washington and Pennsylvania are similar. Washington's 10-day category includes complaints alleging significant potential harm to a resident's physical and/or mental health or safety. Similarly, Pennsylvania characterizes 10-day complaints as those in which residents' needs, including medical, nursing, and dietary, are not being met. Maryland's 10-day time frame states that complaints in this category are those that appear to be especially significant, sensitive, or could attract broad public attention; those forwarded from a government or public official; and those where the provider has a history of poor performance relative to the allegations.

Complaints May Receive
an Inappropriately Low
Investigation Priority

States sometimes place complaints in an inappropriately low investigation category, thus postponing a prompt review. The infrequent use of high-priority levels in some states raises a question as to whether complaints are being appropriately categorized. Some states have explicit procedures or operating practices that result in the downgrading of a complaint's severity. We found several instances of complaints that, in our opinion, were inappropriately placed in a low-priority category.

As shown in table 3, two of the three states we visited seldom placed complaints in the immediate jeopardy category for the 1-year period we analyzed. Maryland did not identify a single complaint as potentially representing immediate jeopardy. Michigan did prioritize some complaints as immediate jeopardy, but they accounted for only 2 percent of total complaints received. The Pennsylvania state auditor also noted that the number of

⁹Washington specifies that the next on-site investigation is within 90 days, whereas Maryland does not have a maximum time frame for the next on-site investigation, other than the maximum 15-month time frame allowed for the annual survey. Washington also has four other categories that do not require an on-site investigation. Priority 5 includes cases where the nursing home has investigated an incident and found that no further action is required. In such cases, the home must retain records for possible future audit by the state agency. Priority 6 cases require no further action beyond recording the complaint, priority 7 cases are resident-to-resident noninjury incidents reported by the home, and priority 8 cases are those not requiring the state to record the complaint.

complaints considered immediate jeopardy in that state had dropped considerably during the first quarter of 1998 in comparison to earlier years, raising the auditor's skepticism and concern.

Table 3: State-Investigated Complaints That Were Considered Potential Immediate Jeopardy, July 1997 Through June 1998

State	Number of complaints classified as immediate jeopardy	Number of immediate jeopardy complaints per 1,000 beds	Immediate jeopardy complaints as a percentage of total complaints investigated
Maryland	0	0	0
Michigan	24	0.5	2
Washington	223	8.6	8

Some states also categorized relatively few complaints in other high-priority categories, such as those that should be investigated within 10 days. For example, Maryland placed most complaints in its lowest-priority category—to be investigated at the next on-site survey. This contrasts with Washington, which categorized nearly 90 percent of its complaints to be investigated either within 2 or 10 workdays. Table 4 compares the use of similar priority time frames among the states visited.

Table 4: Percentages of State-Investigated Complaints in Maryland, Michigan, and Washington, by Priority Category, July 1997 Through June 1998

Priority time frame ^a	Maryland	Michigan ^b	Washington
Within 2 days ^c	0	2	8
Within 10 days	22	N/A	81
Within 45 days	34	92	9
Next survey ^d	44	N/A	3

Note: Percentages may not add to 100 because of rounding.

^aMaryland and Washington define their time frames as workdays, whereas Michigan defines its time frames as calendar days.

^bAbout 5 percent of Michigan's complaints were placed in other miscellaneous categories or their priority was unknown.

^cMichigan's highest priority category requires an investigation within 24 hours.

^dAlthough Michigan's policy includes a priority level that permits complaints to be investigated at the next survey, none of the complaints we reviewed was categorized at this priority level. Maryland defines this category as "the next on-site survey," whereas Washington defines it as being within 90 days or at the next on-site survey, whichever is sooner.

Several states have explicit procedures or operating practices that place serious complaints in lower-priority categories. A Maryland official, for example, acknowledged reducing the priority of some complaints because the state recognized that it could not meet shorter time

frames because of insufficient staff. Similarly, a Michigan official also told us that her office gives a complaint low priority if the resident is no longer at the nursing home when the complaint is received—even if the resident died or was transferred to a hospital or another nursing home.¹⁰ The state may investigate these complaints during the home's next survey or not at all. Failure to investigate such a complaint in a timely manner may compromise the health and safety of other residents who may also be affected by problems cited in the complaint. We identified several cases in which a resident had died or been transferred from the nursing home that were assigned to Michigan's lower-priority (45-day) category, were uninvestigated for several months, or had not yet been investigated at the time of our visit. For example, a complaint in Michigan alleged in July 1998 that a resident died because the home did not properly manage his insulin injections or perform blood sugar tests. Because the resident died, the state had not investigated the complaint as of January 1999. We question why the state agency would not have concerns that this situation might affect other diabetic residents in the home.¹¹

Michigan also delays investigating certain nonimmediate jeopardy complaints against nursing homes that are undergoing federal enforcement action. Officials told us that they adopted this practice to avoid potential confusion that may result from having two enforcement actions pending simultaneously. We believe this practice could unreasonably delay the investigation of serious complaints at nursing homes already identified as violating federal standards.

In reviewing complaints from the states visited, we identified several complaints in two states that raise questions about why they were not considered as potentially immediate jeopardy. Examples of these allegations include the following:

- The complaint alleged that a resident was found dead with her head trapped between the mattress and the side rail of the bed, with her body lying on the floor. The state categorized this complaint as one needing to be investigated within 45 days. The state investigated this complaint within 13 days and determined that 11 of 24 sampled beds had similar side rail violations. Our concern about whether this complaint was appropriately classified is supported by another HCFA region's interpretation of HCFA's guidance to states. The Denver region would have considered this situation to be an immediate jeopardy complaint to be investigated within 2 workdays, noting that "an unexplained

¹⁰In reviewing our draft, Michigan stated that its policy is to investigate complaints whether or not a resident is still in the home.

¹¹In its comments on a draft of this report, Michigan provided additional information about this complaint. It stated that the state did not investigate this complaint because state investigators had investigated the home shortly before the complaint was received and found that previous problems related to treatment of diabetic residents had been resolved. About 8 months after the complaint was received (Mar. 12, 1999), state investigators conducted the most recent annual survey of the home and found no problems relating to the monitoring of diabetic residents. However, we still question why the state did not more immediately investigate the complaint given that (1) the resident died, (2) the state had identified previous problems with this home's treatment of diabetic residents, and (3) the attorney general's office had been notified. This appears to violate Michigan's policy that complaints should be investigated within 24 hours if the incident involves "injury or . . . death or potential criminal activity under investigation by a state or local law enforcement agency."

resident death related to a medical device, side rails, or other restraints exemplifies a possible immediate jeopardy situation requiring an on-site investigation within two workdays."

- Another complaint alleged that an alert resident who was placed in a nursing home for a 20-day rehabilitation stay to recover from hip surgery was transferred in less than 3 weeks to a hospital because of what the complainant termed an "unprecedented rapid decline [in the resident's condition]." One of the members of the ambulance crew transporting the resident to the hospital filed a written report stating that the resident "had dried . . . blood in his fingernails and on his hands . . . sores all over his body . . . smelled like feces, and [was] unable to walk or take care of himself. Patient is in very poor condition as far as his hygiene. I personally feel he was not being properly cared for." The state categorized this complaint as needing an investigation at the next on-site inspection, took more than 4 months to begin its investigation, and determined that the nursing home had harmed the resident.
- Another complaint alleged that the home's staff would not send a resident with maggots in the sores on his feet to the hospital because the home's director of nursing did not want the state agency to be notified by the hospital and investigate the home. The state categorized this complaint, received 105 days before our visit, as needing to be investigated within 45 days, but it had not yet been investigated.
- In another instance, the police reported suspected abuse and neglect to the state survey agency after a resident was brought twice to the hospital emergency room because of falls. The resident's first hospitalization identified a broken elbow, and the second found a contusion on the resident's cheek. The police did not believe the nursing home staff's account of how the resident had sustained these injuries. This complaint, filed 13 workdays before our visit, was being held by the state until the next on-site investigation.

State auditors' reports identified additional complaints that the auditors found should have been placed in a higher category. Examples follow:

- Kansas' auditors said that about 10 percent of 213 complaints reviewed were classified too low, given their potential seriousness. Among the complaints categorized as not requiring an investigation until the earlier of the home's next annual survey or within 6 months of receipt was one alleging that a resident had skin tears, purple lesions, feces and food on his clothing, broken eyeglasses, and was not being fed regularly. Another complaint charged that a nurse's aide abused several residents.
- Pennsylvania's auditors identified several complaints as categorized too low, including one filed by a licensed practical nurse recently employed by the home. The nurse alleged that there had been at least 12 deaths at the home over a 2-week period, including a resident who choked to death because she had mistakenly been given solid food; a resident who was sent to the emergency room because her feeding tube had become dislodged and was entirely within her stomach; and a resident who had received 10 times the prescribed dosage of a medication. This nurse's complaint was placed in the lowest category, delaying its investigation until the home's next annual survey.

**States Frequently Do Not Investigate
Complaints Within Required Time Frames**

States often do not conduct investigations of complaints within the time frames they assign, even though some states frequently place complaints in lower investigation categories to increase the time available to investigate them. Some of these complaints, despite alleging serious risk to resident health and safety, remained uninvestigated for several months after the deadline for investigation. These delays may contribute to investigators being unable to determine whether the allegations are true because, by the time the investigation starts, evidence needed to establish validity may no longer be available.

To determine whether states investigate complaints within state-required time frames, we reviewed state data covering 1 year from July 1997 through June 1998. Table 5 shows the percentage of complaints that met the assigned time frame for investigation.

Table 5: Percentage of State-Investigated Complaints Meeting Time Frame for Investigation, July 1997 to June 1998

Time frame	Number of complaints ^a	Percentage investigated within time frame
Maryland		
2 workdays	0	N/A
10 workdays	47	21 ^b
45 workdays	72	69 ^b
Michigan		
24 hours	24	21 ^c
45 days ^d	1,273	26
Washington		
2 workdays	223	78
10 workdays	2,331	47
45 workdays	252	89
90 workdays	78	100

Note: N/A = not applicable.

^aThis column only includes complaints that had timeliness data available, as discussed in app. I.

^bMaryland's data provide information on the last date of the investigation, but not when the investigation was initiated. Based on our review of complaints received in early 1998, only 1 of 18 complaints was initiated within the assigned time frame of 10 workdays, and only 4 of 11 complaints were initiated within the assigned time frame of 45 workdays.

^cWhen using the federal requirement of 2 workdays to investigate immediate jeopardy complaints, Michigan investigated 42 percent of these complaints on time.

⁴About 5 percent of Michigan's complaints were identified as those to be investigated within miscellaneous time frames. Although state law requires serious complaints other than immediate jeopardy to be investigated within 30 days, Michigan's Department of Consumer and Industry Services changed the 30-day requirement to a 45-day requirement in 1998. As shown, Michigan did not meet even the 45-day time frame in most cases.

We asked each state visited to provide copies of all complaints in the Baltimore, Detroit, and Seattle areas that had not yet been investigated and that exceeded the assigned time frame. Baltimore and Detroit each had over 100 such complaints, while Seattle had 40.¹² From the complaints provided, we identified those for homes having at least three outstanding complaints not investigated within the states' prioritized time frames, and we summarized the allegations of each complaint. Many of these complaints alleged potential resident abuse by staff; resident neglect, including malnutrition and dehydration; preventable accidents; medication errors; and understaffing. See appendix III for this summary.

Delayed Investigations of Complaints Prolong Harm to Residents

Failure by states to investigate complaints promptly can delay the identification of serious problems in nursing homes and postpone needed corrective actions. Furthermore, delayed investigations can prolong, for extended periods, situations in which residents are harmed. Table 6 identifies complaints received in early 1998 in which the state's complaint investigation concluded that the resident had been harmed. In Maryland and Michigan, a large percentage of such cases was not investigated for extended periods.

¹²As discussed I in app. I, this includes only the unassigned complaints in Baltimore. Other assigned complaints were also uninvestigated.

Table 6: Complaints in Which Investigation Substantiated Federal Deficiency and Resulted in Home Being Cited for Actual Harm to One or More Residents

Description of allegations	Days until investigation started	Scope of harm found ^a
Maryland		
Nurse charted that resident's intravenous fluid was flowing well; however, fluid was going under the resident's skin and not into a vein. Resident had to be hospitalized.	139	Isolated
Resident had caked feces all over his body, dried blood under his fingernails and on his hand, and pressure sores all over his body. A member of the ambulance team that transported the resident to the hospital questioned whether the home properly cared for the resident.	130	Isolated
Inadequate supervision led to falls. One resident suffered a dislocated jaw and could not chew. A feeding tube was inserted into the resident. The resident later developed pneumonia, was hospitalized, and was put on life support.	54	Isolated
Three residents were hospitalized with several pressure sores. One resident had a sore that was exposed to the bone. Another resident had four sores; a third resident had three sores. The state noted that the home did not ensure proper nutrition for one of these residents to prevent the development of the sores.	39	Isolated
Michigan		
Resident had multiple pressure sores and multiple fractures caused by falls, resulting in hospitalization.	228	Pattern
Resident had swelling and bruising on chest, shoulder, and forearm. The emergency room diagnosed fractured ribs.	216	Isolated
Resident was verbally abused by an aide, who told resident to go to the bathroom in her diaper after resident asked for a bedpan. The home failed to draw a conclusion about the incident, but suspended the aide. The state noted the home had a history of not being able to draw conclusions about abuse incidents.	152	Isolated
Aide was rough in transferring resident from wheelchair, resulting in laceration needing 25 stitches.	146	Isolated
Resident with history of 13 altercations with other residents hit a resident who suffered a laceration. The home had not implemented safeguards to prevent such occurrences.	112	Isolated
Resident's weight and fluids were not monitored. Also, resident's foot was swollen, possibly requiring amputation. Resident also found sitting in urine, not clean, and missing	99	Pattern

personal property. Resident rushed to emergency room.		
Male aide slapped a female resident and squeezed her hand causing a bruise. Another resident struck a home employee, who slapped the resident's face in response.	88	Isolated
Resident sustained a fractured nose and laceration of her forehead as a result of improper positioning in her wheelchair. Resident sent to hospital for stitches.	45	Isolated
Resident, who had blood drawn, was noted to have a badly bruised hand and elbow. Complainant alleged that a laboratory representative stated that sometimes they "have to get rough" in order to draw blood from residents.	37	Isolated
Home failed to monitor resident's condition; resident became unresponsive and was hospitalized for dehydration and a urinary tract infection. Home failed to use bed side rails for seven residents, resulting in lacerations/injuries to four residents who fell out of bed.	33	Pattern
A resident's leg was fractured three different times, possibly due to rough handling of resident during transfer by aide. Allegation also stated that aides are not properly trained to transfer residents who have fragile bones.	33	Pattern
Resident hit another resident.	17	Isolated
Resident found dead with head between mattress and bed side rail, with body lying on the floor.	13	Isolated
Washington		
Resident had repeatedly developed pressure sores while in the nursing home.	27	Isolated
Resident fell while being transferred from wheelchair to toilet, and as a result, re-broke hip.	9	Isolated
Quadriplegic left the home in an electric wheelchair and died of hypothermia after the battery ran out.	3	Isolated
Inadequate staffing resulting in deteriorated care of many residents. Medications were late, and a diabetic's blood was not tested for sugar level.	1	Widespread
Resident suffered a hairline fracture of the foot while being transferred from wheelchair to bed.	0	Isolated

Note: Data include a complete chronological sample of complaints received in early 1998 that were investigated and resulted in a violation indicating that actual harm had occurred. In Maryland, we reviewed 114 complaints received between January 1 and February 28, 1998; in Michigan, we reviewed 59 complaints received between January 1 and January 15, 1998; and in Washington, we reviewed 132 complaints received between January 1 and January 7, 1998.

*Isolated, pattern, and widespread are terms that state investigators must use to classify the scope of a violation. In general, isolated violations affect one or a limited number of residents and/or occur only occasionally; pattern violations affect more than a limited

number of residents and/or have occurred repeatedly; widespread violations are pervasive, affecting a large number of residents and occurring frequently.

HCFA's Complaint Investigation Standards Are Minimal, and Its Oversight of States' Complaint Practices Is Weak

Although HCFA funds, on average, 71 percent of state agencies' complaint investigation costs, HCFA has established minimal standards for investigating complaints and has conducted little monitoring of states' complaint practices. HCFA provides limited guidance to states on complaints beyond the 2-workday requirement for allegations classified as posing immediate jeopardy to resident health and safety.¹³ HCFA established a taskforce in 1993 to develop more stringent federal policies for complaint investigations, but it was disbanded in 1995, and formal policies were not revised. Finally, HCFA's ability to oversee state's performance in handling complaints is limited because major monitoring efforts are focused instead on annual surveys; it primarily relies on states to develop performance measures for complaint investigations; and it has inadequate reporting systems for capturing the results of complaint investigations.

Previous HCFA Efforts to Strengthen Federal Standards for Nursing Home Complaint Investigations Were Abandoned

Between 1993 and 1995, a HCFA task force worked to develop formal complaint guidance for states and a complaint investigation manual to help state investigators. The task force activities included consideration of additional minimum federal priority and time frame classifications, including requirements that time frames be set for complaints alleging serious care issues, but at levels less than immediate jeopardy. However, the formal guidance and the manual were never finalized or released. HCFA attributes the decision to discontinue this initiative to a shift in HCFA's focus toward revising enforcement regulations and its concern that some states that exceeded the proposed federal standards might weaken their standards.

Instead of formal guidance, HCFA sent a portion of the task force's work to its 10 regional offices as a set of optional protocols. These were released as "tools, not rules" for specific situations an investigator may encounter while conducting an on-site complaint investigation. These protocols did not address the prioritization and timeliness aspects of complaint investigations. This optional guidance has not been widely used. Officials at several HCFA regional offices did not recall receiving these on-site investigative protocols. Another HCFA regional office reported that it did not release the document to states in its area because the document appeared to be in draft form. HCFA does not provide additional guidance to states on ways to manage complaint workloads efficiently, how to categorize complaints, or when to expand a review beyond the residents involved with the original complaint.

¹³HCFA's request for state budget proposals for fiscal year 1999 noted that "in some cases, it may be appropriate for the complaint to be investigated during the next scheduled visit to the facility."

In contrast, the HCFA regional office in Boston established its own task force to enhance the protocols. The region adopted its own guidance for how state agencies should classify complaints. This guidance suggests that "at a minimum, your [state] agency should have at least three action levels based on the degree of safety or health hazard alleged: high-level action, mid-level action, and low-level action."

Although HCFA had not established a priority and timeliness scheme for complaints other than those alleging immediate jeopardy to residents, the form it used for states to report the results of investigations included four priority and timeliness categories. The form asked states to specify whether an investigation was conducted within 2, 10, or 45 workdays or at an annual survey. It is intended for reporting state agencies' investigation results for all types of health care facilities—including home health agencies and clinical laboratories—as well as nursing homes. Thus, it did not formally establish additional time frames for nursing home investigations. However, some states have interpreted the categories included on the HCFA form as suggested priority and timeliness categories and have modeled their standards after them. For example, officials in Maryland and Washington indicated that they adopted their priority categories in part to conform with the categories on the HCFA form. Other states, however, maintain complaint priority levels and time frames that are distinct, and often less stringent, than those identified on the HCFA form.

Federal Monitoring of States' Complaint Practices Is Limited

HCFA's major efforts to monitor states' performance in surveying and certifying nursing homes are largely focused on annual surveys—not on complaint investigations. HCFA requires its regional investigators to replicate or observe a 5-percent sample of state investigators' nursing home inspections and requires states to develop performance measures and quality improvement programs. However, nearly all of the state nursing home inspections that HCFA monitors are annual surveys rather than complaint investigations. Even though HCFA has begun requiring states to include complaint investigations as part of its performance measurement and improvement programs, some states have not yet begun to do so. For states that have developed quality improvement programs, some programs have not identified or focused on concerns that state auditors and we have found.

Few Federal Monitoring Surveys Are Performed for Complaint Investigations

HCFA's principal method for monitoring state agencies' performance in certifying nursing homes is through the statutory requirement that HCFA staff conduct monitoring surveys of at least 5 percent of the states' nursing home investigations. This process allows HCFA either to repeat a state's survey of a nursing home and compare findings or to observe state investigators while they perform a nursing home survey. However, these federal monitoring surveys are largely intended to focus on annual surveys rather than on complaint investigations, and few federal monitoring surveys are conducted of complaint investigations.

In 1998, of the 824 federal monitoring surveys that HCFA conducted nationwide, only 39 were of complaint investigations. Furthermore, 25 of the 39 were conducted by HCFA's Chicago regional office, which oversees 6 states, and 10 were conducted in Illinois. Therefore, in the remaining 44 states and the District of Columbia, only 14 federal monitoring surveys focused on complaint investigations. Thus, federal monitoring surveys provide HCFA with little insight into state agencies' performance in conducting nursing home complaint investigations.

As of October 1, 1998, HCFA had revised its requirements for federal monitoring surveys, allowing its regions to include only a small number of complaint investigations in each state to meet the requirement that 5 percent of surveys be monitored. Under this revision, HCFA may assess only one complaint investigation as part of its quota for most states, while even in the largest states, HCFA may include no more than four complaint investigations as part of the 5-percent requirement. As a result, it is clear that HCFA intends that federal monitoring surveys principally should be a method to oversee state agencies' performance in conducting annual surveys, resulting in minimal oversight of states' complaint investigations.

Initial State Quality Improvement Reports Identify Few Problems With Complaint Practices

HCFA requires each state to evaluate its performance in complaint investigations beginning in 1998 as part of the State Agency Quality Improvement Program. However, our review of the 1998 reports submitted to HCFA by states that either we visited or had a recent state auditor's report¹⁴ indicated that several states had not yet developed performance measures or improvement plans related to nursing home complaints, and that the states that had evaluated complaint processes ignored concerns that we and the state auditors raised. Furthermore, under the new Quality Improvement Program, HCFA regional offices appeared to be less directly involved in evaluating state agencies' performance in complaint handling than with previous oversight approaches.

Among the states visited,

- Maryland had not developed a Quality Improvement Program or baseline performance measures for nursing home complaints.¹⁵
- Michigan's final 1998 quality improvement report noted that staff turnover had delayed its ability to begin evaluating whether all complaints were investigated and processed within the time frames but stressed that the state agency "feels confident that this [performance standard] will be (and currently is) met." This statement conflicts with our findings that

¹⁴We reviewed the reports submitted by the 11 states reviewed by state auditors and the 3 states we visited.

¹⁵While not reflected as a part of HCFA's quality improvement program, Maryland's director of the survey and certification unit indicated that the unit has implemented some improvements and is planning others. For example, the unit has hired three additional staff persons and is planning to merge the complaint and survey units.

most investigations in Michigan were conducted later than the 45-day time frame adopted by the state agency.

- Although Washington's quality improvement program includes performance measures related to training staff in conducting complaint investigations and properly documenting the results, it did not evaluate the timeliness of complaint investigations. As noted above, we found that Washington categorizes its complaints at a higher priority level than do Maryland and Michigan and is more timely in investigating them. Nevertheless, Washington met its time frames in only about 55 percent of the complaints investigated.

For the states reviewed by state auditors, our review of the quality improvement reports submitted to HCFA showed that several states had not yet initiated quality improvement programs while few others identified concerns regarding complaints. Examples follow:

- New York had not yet established performance standards for nursing home complaints.
- Tennessee reported that it planned to begin implementing new complaint performance standards in October 1998.
- Wisconsin cited the implementation of a new data system as the cause of its delay in tracking complaints as part of quality improvement efforts but stressed that "our belief is that we are fine, but we have no data to support or refute this belief."

North Carolina's 1998 quality improvement report acknowledged that the state agency "has fallen behind significantly on investigating complaints within 60 days for nursing homes due to [a] shortage in nursing staff and the large number of complaints." As remedial actions, North Carolina reported that it intended to reevaluate its hiring practices, increase salaries to attract and retain qualified staff, improve training, and request that the state legislature either provide additional funds or repeal the 60-day statutory requirement.

The relatively new process relies largely on self-measurement of performance, resulting in less direct involvement by the HCFA regional offices than previous approaches to evaluating state agencies' performance. For example, HCFA regional offices are no longer required to review state procedures for complaint investigations and other types of nursing home oversight. Based on our interviews, some HCFA regional offices have had very little involvement in developing or monitoring states' quality improvement plans, even though this involvement is a HCFA requirement.

Inadequate Reporting Systems Hamper Effective Federal and State Management of Complaint Investigations

An effective complaint reporting system is important to support both federal and state efforts to maintain an accurate and complete record of a nursing home's federal compliance history as well as to track the state agencies' performance in complaint investigations. Tracking of complaints is integral to identifying the status of complaint investigations and to managing complaint workloads to appropriately protect residents' health. In particular, a full

compliance history is key to several parts of the survey and certification process, such as HCFA's enforcement and oversight of standards, states' prioritization of complaints, and HCFA's ability to provide full information to consumers via its Internet page and other sources.¹⁶ We found that inadequacies in HCFA's data system and the linkage between state and federal systems hinder HCFA's and states' ability to adequately track the status of complaint investigations and for HCFA to maintain a full nursing home compliance history. In short, one HCFA official stated that the complaint system is "not used as a management tool."¹⁷

HCFA requires states to develop tracking systems and to submit summary information on all complaint investigations. For monitoring purposes, HCFA maintains a database of nursing home complaint investigation information. Although HCFA standards require states to report this information, the process for collecting it results in inaccurate and incomplete information. For example, HCFA collects summary information for on-site complaint investigations with a form that was created for recording information about a single complaint. Some states, including Maryland and Michigan, use the form for multiple complaints. Therefore, timeliness, prioritization, and other important tracking information that relates to multiple complaints is reported as though it applies to one complaint. In this situation, states typically record the highest priority level assigned to any of the individual complaints and are limited to choosing timeliness dates reflective of only one of the complaints. As a result, HCFA is unable to effectively monitor state's performance on prioritization and timeliness.¹⁸

In our report on California nursing homes, we determined that the results of complaint inspections are often cited as state, not federal, deficiencies.¹⁹ Thus, the results of complaint investigations may not appear in federal databases. Furthermore, state officials reported that complaints might appear to be unsubstantiated in federal databases when the state has actually substantiated the complaint. In contrast, Washington and Michigan report that they record most violations they identify in both federal and state information systems. For example, Washington has developed a crosswalk between its state licensing and federal regulations to assist providing full information in both federal and state information systems.

Overall, there is also a time lag on states reporting data to HCFA. Washington, for example, estimated that its input into the federal data system was 3 months behind. HCFA estimated

¹⁶HCFA recently has begun posting results of nursing homes' most recent annual survey on the Internet, available at <http://www.medicare.gov/nursing/home.asp>. Results of complaint investigations are not publicly available from the Internet.

¹⁷For an assessment of the weaknesses of HCFA's management information systems and the impact those weaknesses have on HCFA's enforcement activities, see GAO/HEHS-99-46, Mar. 18, 1999.

¹⁸HCFA regional offices are also required to maintain a complaint log with the information reported by states. We spoke with all HCFA regions, and none indicated that it had any additional tracking system for complaints other than the central HCFA tracking system.

¹⁹GAO/HEHS-98-202, July 27, 1998.

that some states might lag by as much as 6 months in entering complaint investigation information into federal management systems.

Conclusions

Our work in selected states reveals that serious complaints alleging harm to residents often remain uninvestigated for extended periods. Such delays do not provide this vulnerable population the protections intended by the federally mandated complaint investigation process. Some practices, such as Washington's ready acceptance of phone complaints and its relatively prompt investigation, as well as the HCFA Boston office's guidance to states recommending improved prioritization of complaints, merit replication. Despite these positive efforts, we identified frequent systemic weaknesses in HCFA's and many states' practices that can leave nursing home residents in poor care and unsafe conditions for extended periods. The combination of inadequate state practices and limited HCFA guidance and oversight have too often resulted in extensive delays in investigating serious complaints alleging harmful situations, a lack of careful review of states' policies and practices, and incomplete reporting on nursing homes' compliance history and states' complaint investigation performance.

Recommendations

To make complaint investigations a more effective tool for protecting nursing home residents' health and safety, we recommend that the HCFA Administrator revise federal guidance and ensure state agency compliance through the following actions:

- Develop additional standards for the prompt investigation of serious complaints alleging situations that may harm residents but are categorized as less than immediate jeopardy. These standards should include maximum allowable time frames for investigating serious complaints and for complaints that may be deferred until the next scheduled annual survey. States may continue to set priority levels and time frames that are more stringent than these federal standards.
- Strengthen federal oversight of state complaint investigations, including monitoring states' practices regarding priority-setting, on-site investigation, and timely reporting of serious health and safety complaints.
- Require that the substantiated results of complaint investigations be included in federal data systems or be accessible by federal officials.

Agency, State, and Industry Comments and Our Response

We obtained comments on our draft report from HCFA and the three states we visited. (See apps. IV through VII for their written comments.) In general, HCFA and the states concurred with our recommendations and highlighted efforts being taken to improve complaint investigations. They also suggested clarification on certain findings and technical changes, which we included in the report where appropriate.

HCFA, in concurring with our recommendations, also immediately announced several initiatives to address issues we raise. These include

- a new interim requirement that states should investigate complaints alleging actual harm to residents within 10 workdays, and a complaint improvement project with the intention of developing additional minimum standards for complaint investigations;
- increased federal oversight of complaints, including allowing HCFA regional offices to conduct additional monitoring surveys based upon complaints and new state agency performance measures relating to complaints; and
- improved reporting on complaint information, including a review of the form states use to report complaint information to HCFA, further direction to states requiring that complaint findings be included in the federal as well as state database in a timely manner, and a review of potential long-term improvements in the federal data system.

Maryland, Michigan, and Washington each highlighted resource limitations as contributing to the problems we identify. Specifically, Maryland noted that in recognition of many of the problems we identify, the state has recently hired additional staff and plans additional improvements, including merging its complaint and annual survey investigative staff and improving the tracking of complaints. Maryland also commented that the scope of our work was narrowly focused on complaint investigations and, as only one component of its broader nursing home oversight efforts, should not be used to evaluate the state's entire regulatory process. While we concentrated this aspect of our work on complaints, we continue to believe that, in coordination with annual surveys, complaint investigations are an essential component of state efforts to protect residents and ensure that nursing homes provide adequate care. They afford a unique opportunity to increase state inspectors' unexpected presence in homes and to target specific areas of potential problems identified by residents and other concerned individuals.

Michigan's comments noted that prior to the period we examined the state had experienced a loss of staff and that it has been hiring and training additional investigators. Michigan also reiterated its criteria for including complaints in its highest priority level. However, we found several cases that appear to meet these criteria but were not classified as requiring a 24-hour visit. Michigan also noted that several state practices we highlight were developed with guidance from the HCFA regional office, including investigating complaints concurrently with annual surveys and delaying the investigation of certain complaints regarding nursing homes nearing the deadline for enforcement actions. Michigan disputes that its policy or practice places egregious complaints in a lower priority level. However, we remain concerned that state investigators we interviewed reported that some complaints where residents died or left the nursing home would not be investigated until the next on-site inspection. Furthermore, several cases we reviewed where a resident had died or had been transferred from the home were assigned to Michigan's lower (45-day) category, were uninvestigated for several months, or had not yet been investigated at the time of our visit. Michigan indicated that it plans a more thorough review of its handling of complaints and intends to make recommendations to address any concerns it identifies by April 1999.

Washington concurred with the importance of an effective complaint system and stressed attributes of its system, including prioritizing most complaints at a high level and a highly-trained professional staff. Washington acknowledged that, because of the large volume of complaints categorized as requiring an investigation within 10 days and the need for increased resources, the timeliness of complaints within this category depends on investigators' determinations of which complaints are the most serious.

We also provided a copy of the report for review by the American Health Care Association (AHCA) and the American Association of Homes and Services for the Aging (AAHSA). AHCA officials expressed agreement with the report's recommendations. Both AHCA and AAHSA officials noted that the report summarizes some uninvestigated complaints and that the allegations had not yet been substantiated or unsubstantiated. We acknowledge that many of the complaints summarized reflect allegations rather than substantiated problems and believe that the report adequately reflects that many had not yet been investigated at the time of our visit to determine their validity. We included these allegations to reflect the information that a state agency would have as it determines the priority level to assign complaints and how promptly to investigate them.

- - - - -

We are making copies of this report available to the HCFA Administrator, appropriate congressional committees, and interested parties upon request.

Please contact me or Kathryn G. Allen, Associate Director, at (202) 512-7114 if you or your staffs have any further questions. This report was prepared by Jack Brennan, Mary Ann Curran, C. Robert DeRoy, Gloria Eldridge, and Chick Walter under the direction of John Dicken.



William J. Scanlon
Director, Health Financing
and Public Health Issues

Contents

	<u>Page</u>
Letter	1
Appendix	
I	Scope and Methodology
II	Nursing Home Complaint Investigation Expenditures, 1998
III	Summary of Unassigned or Uninvestigated Complaints for the Baltimore, Detroit, and Seattle Metropolitan Areas
IV	Comments From the Health Care Financing Administration
V	Comments From the Maryland's Department of Health and Mental Hygiene
VI	Comments From Michigan's Department of Consumer and Industry Services
VII	Comments From Washington State's Department of Social and Health Services

Abbreviations

AAHSA	American Association of Homes and Services for the Aging
AHCA	American Health Care Association
HCFA	Health Care Financing Administration

HEALTH CARE FINANCING ADMINISTRATIVE



ADDRESSEE:

Deborah Adler

PHONE: _____

FROM:

Maria Martin
OFFICE OF THE ADMINISTRATOR
200 INDEPENDENCE AVE., S.W.
ROOM 314G
WASHINGTON, DC 20201

PHONE: 202-690-6726

FAX : 202-690-6262

TOTAL PAGES:

17

ADDRESSEE'S FAX MACHINE NUMBER:

456-5557

DATE:

3/11/99

REMARKS:

March 1999

NURSING HOMES

Complaint Investigation Processes Inadequate to Protect Residents

Notice:

This draft is restricted to official use.

This draft report is being provided to obtain advance review and comment from those with responsibility for the subjects it discusses. It has not been fully reviewed within GAO and is, therefore, subject to revision.

Recipients of this draft must not, under any circumstances, show or release its contents for purposes other than official review and comment. It must be safeguarded to prevent publication or other improper disclosure of the information it contains. This draft and all copies of it remain the property of, and must be returned on demand to, the General Accounting Office.

B-281767

March 22, 1999

The Honorable Charles E. Grassley
Chairman

The Honorable John B. Breaux
Ranking Minority Member
Special Committee on Aging
United States Senate

The nearly 1.6 million elderly and disabled residents confined to nursing homes are a highly vulnerable population. They are frequently dependent on extensive assistance in basic activities of daily living like dressing, grooming, feeding, and going to the bathroom, and many require skilled nursing or rehabilitative care. Nursing homes that participate in Medicare and Medicaid, the vast majority of nursing homes, receive about \$50 billion in federal and state payments from these programs. For these nursing homes, providing adequate care is a federal mandate backed by about \$210 million in federal funding going to state agencies that inspect and certify nursing homes' compliance with quality standards through annual surveys and complaint investigations. About \$42 million of this goes to fund investigations of complaints that may be lodged by various sources, including residents, their families, or nursing home employees, or of incidents of potential abuse or neglect that nursing homes must report to states.

In our July 1998 report to you, we found that unacceptable care was a problem in many

California nursing homes, including 1 in 3 where state surveyors found serious or potentially life threatening care problems. We also found that federal and state oversight is not sufficient to guarantee the safety and welfare of nursing home residents.¹ In a companion report issued last week, we further found that current federal enforcement efforts are lacking in their ability to ensure sustained compliance with federal standards for nursing home care.²

Concerned that annual surveys alone are inadequate to meet the federal goal of ensuring nursing home residents' health and safety, you asked us to examine how states implement the federal requirement for nursing home complaint investigations. Complaint investigations provide a unique opportunity to identify and correct potential care problems because they can provide a more timely alert than annual inspections, and they target specific areas of potential problems identified by residents, their families, concerned public, and even the facility itself. Specifically, this report assesses the effectiveness of (1) state complaint investigation practices as a component of the system to assure sustained compliance with federal nursing home quality of care standards and (2) the Health Care Financing Administration's (HCFA) role in establishing standards and conducting oversight of states' complaint investigation practices as well as using complaint investigations to assure compliance with nursing home standards.

¹California Nursing Homes: Care Problems Persist Despite Federal and State Oversight, GAO/HEHS-98-202 (July 27, 1998).

²Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards,

To develop this report, we examined state nursing home complaints investigation practices in 3 states (Maryland, Michigan, and Washington) and reviewed 11 state auditors reports from December 1995 through 1998 that examined their states' practices.³ The states we visited were selected to be geographically diverse and represent different approaches to complaint investigations. In each of these 3 states, we (1) interviewed state officials and complaints investigators and obtained documentation regarding their procedures and practices, (2) reviewed complaints received in early 1998, (3) reviewed complaints that had not yet been investigated at the time of our visit in late 1998 or early 1999, and (4) analyzed data on all complaints received in 1997 and the first half of 1998. For each of the 14 states, we also reviewed state agency quality improvement program reports submitted to HCFA at the end of 1998. In addition, we interviewed HCFA officials, including representatives of each of HCFA's 10 regions, regarding federal guidance to and oversight of state agencies. We also obtained from HCFA data on federal and state expenditures on nursing home complaint investigations for all states. (See appendix I for a more detailed description of our scope and methodology.) We conducted our work between October 1998 and March 1999 in accordance with generally accepted government auditing standards.

RESULTS IN BRIEF

Federal and states' practices for investigating complaints about care provided in

GAO/HEHS-99-46, (March 18, 1999).

³The state auditors' reports examined Iowa, Kansas, Kentucky, Louisiana, New York, North Carolina, Ohio, Pennsylvania, Tennessee, Texas, and Wisconsin.

nursing homes are not as effective as they should be to promptly respond to resident concerns. As a component of broader efforts to oversee the quality of care in nursing homes, complaint investigations provide a unique opportunity to promptly protect individual residents in harmful situations as well as identify broader potential concerns about the quality of care provided in a facility. Among the states we examined, we found numerous problems in these states' practices. Problems we identified include:

- procedures that discourage the filing of complaints;
- understatement of the seriousness of complaints; and,
- failure to investigate serious complaints promptly.

As a result, serious complaints alleging that nursing home residents are being harmed can remain uninvestigated for weeks or months. Such delays can unnecessarily prolong situations in which residents' face abuse, neglect resulting in serious care problems like malnutrition and dehydration, preventable accidents, and medication errors.

Although federal funds finance over 70 percent of complaint investigation expenditures, HCFA plays a minimal role in providing states with direction or oversight regarding complaint investigations. HCFA has left it largely to the states' interpretation as to which complaints are so serious that they must be investigated within the federally-mandated 2 workdays. HCFA has no formal requirements for the

prompt investigation of other serious complaints that could harm residents but are not classified as potentially placing residents in immediate jeopardy. HCFA's oversight of state agencies that certify federally qualified nursing homes has not focused on complaint investigations. We found that:

- ✓ A HCFA initiative to strengthen federal requirements was discontinued in 1995, and resulting guidance developed for states' optional use has not been widely adopted.
- Federal reviews of state nursing home inspections are primarily intended to focus on the annual survey of nursing homes, and very few are conducted of complaint investigations;
- Since 1998, HCFA has required state agencies to develop their own performance measures and quality improvement plans for their complaint investigations, but for several states we reviewed complaint processes were addressed superficially or not at all;
- HCFA reporting systems for nursing home's compliance history and complaint investigations do not collect timely, consistent, and complete information.

We are recommending enhanced federal standards to strengthen requirements for states to promptly investigate serious complaints alleging situations that may harm residents, increased federal monitoring of states' performance in responding to complaints, and improved tracking of the substantiated findings of complaints investigations. Such steps can strengthen the ability of federal and state regulators to

use complaints investigations to protect and improve the care nursing home residents receive.

BACKGROUND

The federal government, through HCFA, has responsibility for establishing requirements that nursing homes must meet to participate in the Medicare and Medicaid programs and ensuring that these standards are met. Nearly all nursing homes accept residents with either Medicare or Medicaid, and these programs paid nearly \$50 billion to nursing homes in 1997.

The Omnibus Budget Reconciliation Act of 1987 revised the standards for homes' participation in these federal programs and defined federal and state roles for ensuring that nursing homes meet these standards. In this regulatory framework, states (1) license nursing homes to do business in the state, (2) certify to the federal government after by conducting reviews of nursing homes whether homes are eligible for Medicare and Medicaid payment, and (3) investigate complaints about care provided in the homes. The states are required to conduct annual surveys of homes and to investigate specific complaints regarding nursing homes. While the annual surveys seek to provide a nationally uniform process to evaluate whether nursing homes' meet a comprehensive range of federal standards, they allow for only widely spaced inspections of nursing homes that are often predictable in their timing.⁴ Complaint

⁴HCFA has recently initiated efforts intended to reduce the predictability of annual surveys.



Comments of the Health Care Financing Administration (HCFA)
on the General Accounting Office (GAO) Draft Report
"Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards"

In July 1998, the Clinton Administration announced a broad and aggressive new initiative to improve enforcement of nursing home regulations. This General Accounting Office (GAO) report, which examines conditions in nursing homes over a period from July 1995 to October 1998 (just after the new initiative was launched), underscores the need for this initiative and will help sharpen our focus on areas that need to be addressed. We generally concur with the report's four specific recommendations, and are already taking actions to address them.

There has been substantial improvement in nursing home quality since 1995, when the Clinton Administration began enforcing the nation's toughest-ever enforcement regulations. However, our July 1998 Report to Congress and a July 1998 GAO report made clear that more needed to be done. That is why, building on the earlier reforms, the President in July 1998 unveiled an aggressive initiative to further strengthen enforcement and assure quality care.

We are pleased that the current GAO report recognizes our efforts to address problems both we and the GAO identified last year. We agree that further refinements to our enforcement initiative are needed. And we remain committed to taking appropriate steps to ensure that nursing home residents are safe and receive quality care, and we will continue to work with the States, Congress, residents and their families, resident advocacy groups, and nursing home providers to advance this essential mission. We would like to note that, since the time period analyzed in the current GAO report, we have implemented many aspects of our new enforcement initiative:

Faster Remedies

As part of the President's nursing home initiative, and as mentioned in this report, HCFA has expanded its definition of the type of facility for which HCFA would take an immediate enforcement action without a grace period (i.e., an opportunity for the facility to correct before sanctions are imposed). We previously labeled these facilities as "poor performing facilities (PPFs)". However, we are now revising our guidance to remove this label, and provide, in its place, direction about when facilities will be given an

opportunity to correct. The guidance will make the assumption that unless a facility has no actual harm on the current survey it would not automatically be given an opportunity to correct before sanctions are imposed. Because facilities have no right to a period of correction prior to the imposition of sanctions, there could be other instances where facilities would not be given such an opportunity; for example, where a facility's pre-termination history indicated no commitment to achieve and maintain compliance with participation requirements, we believe it would be appropriate to impose sanctions immediately.

Enhanced Enforcement Training

HCFA has been vigorous in encouraging States to apply appropriate sanctions for the noncompliance identified in the President's initiative. We will be providing training and guidance to States beginning this Spring on the nursing home initiatives including enforcement, use of quality indicators in the survey process, survey tasks in the areas of medication review, pressures sores, dehydration, weight loss, and abuse prevention.

Enhanced Oversight of Selected Facilities

HCFA has identified facilities in each State for more frequent inspection and intense monitoring. In selecting these special focus facilities (SFFs), HCFA scored each nursing home based on the results of its most recent annual inspection and any substantiated complaints during the past 2 years. HCFA presented each State survey agency with the names of those homes that generated the highest scores. States selected two facilities and have begun to monitor them more frequently.

Baseline data has been collected on each facility and monthly status reports are required. The monthly status report includes any survey outcomes, complaint investigations, enforcement actions, or press attention for each facility. The purpose of more intense monitoring of these facilities is to determine whether or not closer scrutiny and imposition of immediate remedies will have a lasting effect on these homes, i.e., whether the "yo yo" compliance history is affected. HCFA will conduct systematic analysis to determine if more intense monitoring is effective and if there are innovations with monitoring these facilities which can be used in the overall program.

Stronger Federal Oversight

HCFA has initiated a national program for improving the accuracy and consistency of State survey results. In October 1998, a standardized system for evaluating State survey performance was implemented. The Federal Oversight and Support Survey (FOSS) is a structured protocol for HCFA staff to use onsite in assessing the State survey teams' adherence to Federally mandated procedures and policies. Where training needs or corrective actions are identified, HCFA staff works with the State to assure that the necessary changes are implemented. We expect that this more standardized and

aggressive approach to oversight will improve national consistency in the performance of nursing home surveys.

Quality of Care Enhancements

HCFA is in the process of implementing a wide range of initiatives to improve its ability to detect and prevent bed sores, dehydration, and malnutrition in nursing homes. In conjunction with national experts in nursing home care and quality indicator development, HCFA is developing a systematic data driven process for assessing quality problems in nursing homes. This data driven surveillance system will use indicators of potential care problems for facility residents to identify a sample for more in-depth on-site assessment including a larger sample to review for weight loss and pressure sores. National roll outs of this systematic approach are expected to be completed by the end of 2000 with an interim enhancement to the survey process implemented in 1999. In addition, HCFA staff are working with the American Dietetic Association, clinicians, consumers and nursing homes to share best practices for residents at risk for weight loss, dehydration, and pressure sore development. This includes better guidance and training for surveyors on standards of care practices. A national campaign to educate residents, families, other consumers, and nursing home staff about the risks of malnutrition and dehydration as well as nursing home residents' rights to quality care in nursing homes will begin this year.

Abuse Prevention Campaign

Over the past 8 months, HCFA has concentrated efforts on the reduction of abuse and neglect in facilities. A national abuse and neglect forum consisting of representatives from groups concerned with the frail elderly and disabled has been formed. A survey protocol developed through the forum workgroup for evaluating nursing homes' abuse and neglect prevention processes will be implemented nationally by July 1999. A national consumer education campaign on prevention and detection will also be inaugurated in 1999.

Management Information System

HCFA is in the process of a major redesign and enhancement of its information system for nursing home quality. The goal is to implement in stages a system that is both user friendly for HCFA, State survey agencies, providers and consumers, and includes information necessary for nursing home quality of care evaluation and improvement. In June 1998 the first segment of this information system began with the development of State and national repositories with resident-specific data on declines and improvement (Minimum Data Set (MDS) longitudinal data). In July 1999, HCFA will start using quality indicators developed by national experts to analyze MDS data and identify domains of potential care problems. These quality indicator reports will be available to HCFA and State survey agencies for enhancing the survey system as well as to providers

for internal quality improvement activities. In addition, in July 1999, an improved system for information collection, consolidation, and integration will be available to State survey agencies. State staff and managers will be able to generate, for individual facilities, tables that include relevant survey results as well as quality indicator information. This improved information system will enhance States' ability to assess the overall performance of an individual nursing home and to better manage survey resources. Future stages of the improved information system on facility quality will include: enhancement to the State systems on enforcement actions; major revisions to the current On-line Survey, Certification and Reporting (OSCAR) system to provide better and more integrated national information in a more user friendly environment; consumer information on quality indicators; updated quality indicators; and better national enforcement data. HCFA will proceed as quickly as possible with development of its improved information system for nursing home quality although there will be some delays attributable to Y2K priorities.

Consumer Information

HCFA is working to make survey results more accessible to the public. HCFA's new internet site -- Nursing Home Compare -- gives families and consumers direct Internet access to comparative information about nursing homes as well as provides incentives for nursing homes to improve the quality of care. Since the site was established last September, approximately 826,000 pages have been viewed and we are working with consumers, industry and others to make it more useful to consumers and their families. These and other such projects reflect HCFA's commitment to improving care in nursing homes through better information, education and enforcement.

Budget

In support of the nursing home initiatives, Congress appropriated \$4 million to the \$118.7 million in Medicare survey and certification funds requested for fiscal year (FY) 1999. And in order to ensure adequate funding of these efforts, the Clinton Administration intends to reprogram \$4 million from other activities so that a total of \$126.7 million will be directed to the nursing home related survey, certification and enforcement initiatives for FY99. These funds are being used primarily to support key improvements in state survey processes, including:

- staggering the beginning of at least 10% of the annual surveys during the morning and evening hours and on weekends;
- providing enhanced monitoring of those nursing homes who past compliance and complaint survey records indicate a poor history of compliance;
- revising the definition of and targeting nursing homes in which actual harm was found in the current survey and in either the last standard survey or an intervening complaint survey and;

- altering the survey protocol and resident sample selection in a way that identifies residents more susceptible to abuse and to having health problems associated with the lack of proper nutrition and hydration.

The Administration has proposed to expand its nursing home survey, certification and enforcement related funding in the FY2000 budget request to \$135.9 million, an increase of \$9.2 million over the FY 1999 funding. With the approval of this funding, HCFA envisions making significant gains in improving the care of beneficiaries and in providing the oversight necessary to assure that all are working toward this common goal.

GAO Recommendation

To strengthen its ability to ensure that nursing homes maintain compliance with Medicare and Medicaid quality-of-care standards, we recommend that the Administrator of HCFA take the following actions:

- Improve the effectiveness of civil money penalties. The Administrator should continue to take those steps necessary to shorten the delay in adjudicating appeals, including monitoring progress made in reducing the backlog of appeals.

HCFA Comment

We concur. We should note, however, that the Health Care Financing Administration (HCFA) does not oversee the Departmental Appeals Board (DAB), which is housed in the Office of the Secretary of the Department of Health and Human Services. However, HCFA supports the Secretary's efforts to increase resources at the DAB in an attempt to improve the effectiveness of the civil money penalty (CMP) sanctioning process. The DAB operates independently from HCFA but its workload has increased substantially as a result of OBRA 1987 and we expect it to continue to increase in view of our new enforcement efforts. In the fiscal year (FY) 2000 budget, the President has proposed to double the number of Administrative Law Judges at the DAB. Since providers are entitled to a DAB hearing before CMPs can be collected, we are hopeful that doubling the number of judges will help with the processing of appeals, which may thereby improve the effectiveness of CMPs specifically, and our enforcement efforts overall.

As announced last July, we are developing a new regulation which will allow States to impose CMPs for each instance of a violation regardless of the amount of time the facility was out of compliance with requirements. This additional enforcement option will give States greater flexibility to assess penalties quickly.

Recommendation

- Strengthen the use and effect of termination. The Administrator should (1) continue Medicare and Medicaid payments beyond the termination date only if the home and State Medicaid agency are making reasonable efforts to transfer residents to other homes or alternative modes of care, (2) use longer "reasonable assurance periods" before reinstating terminated homes, and (3) revise existing policies so that the pre-termination history of a home is considered in taking a subsequent enforcement action.

HCFA Comment

- (1) Continue Medicare and Medicaid payments beyond the termination date only if the home and State Medicaid agency are making reasonable efforts to transfer residents to other homes or alternative modes of care.

We concur. As noted in the draft, existing Medicaid regulations provide that Federal Financial Participation (FFP) for institutional services may be continued for up to 30 days after the effective date of termination if the Medicaid residents were admitted to the facility before the effective date of termination *and* if the State is making reasonable efforts to transfer those residents to other facilities. Under current rules and procedures, Medicare also makes funds available but does not explicitly require a State's effort to transfer residents.

While HCFA's guidance to the States about resident transfers at §3008.2 of the State Operations Manual, reiterates the regulatory language and provides operational guidance about relocation considerations and activities, it does not currently include a Federal oversight component of States' transfer efforts. HCFA agrees that Medicaid facilities should not be automatically paid for 30 additional days of care for the residents after termination of the facility from the program unless reasonable efforts to transfer residents are being made.

Since the GAO findings indicate that there may be inconsistent and inappropriate application of this rule, HCFA will conduct a baseline study of the 30 involuntary terminations taken last fiscal year. In addition, we will assess whether procedures should be available for Medicare payment beyond termination if it is necessary. The study will determine what resident transfer procedures the States and the facilities put into place over the 30 days following termination, if any. HCFA will determine if oversight and payment practices and policies existed and if they were (and are) being applied appropriately and consistently. HCFA will also attempt to determine what happened subsequently to the facility, e.g., facility closed and ultimately transferred the residents;

facility stayed open and paid for care of the residents not transferred; facility sold to others, etc. Based on the findings, HCFA will take action as determined to be appropriate.

(2) Use longer "reasonable assurance periods" before reinstating terminated homes.

We do not concur. While we appreciate and agree with the GAO's concern that terminated homes are sometimes readmitted by States too quickly, we do not believe that arbitrarily requiring a longer "reasonable assurance" period for all facilities would give HCFA and the States the flexibility they need to administer the Medicare and Medicaid programs. We also question whether the scope of the problem is as significant as GAO suggests.

Currently, HCFA's State Operations Manual provides States with several examples to assist in determining the length of a reasonable assurance period. The reasonable assurance period can be anywhere from one to six months. This guidance recognizes that there may be situations where HCFA terminated a nursing home from the Medicare program for failure to correct its deficiencies within the statutorily required 6-month period, and for which a long reasonable assurance period would not necessarily be in the best interest of the nursing home residents or the State. For example, a facility had a physical environment deficiency which caused no actual harm, ran out of time to correct it, was involuntarily terminated, and then subsequently fixed the problem. In this case, HCFA may choose a short reasonable assurance period because of the type of deficiency which caused the involuntary termination. There also may be instances where the nursing home is in an underserved or rural area where there may be limited access to care.

We also note that under current law there is no parallel requirement for reasonable assurance for Medicaid facilities. That requirement was removed by OBRA 1987. To the extent that this is a problem in the majority of nursing homes, we are willing to discuss reasonable assurance in more detail if the Congress wants to examine this issue further.

(3) Revise existing policies so that the pre-termination history of a home is considered in taking subsequent enforcement action.

We concur. While current Federal regulations at §488.404(c) and operating instructions at §7400 of HCFA's State Operations Manual provide that a facility's prior history of noncompliance may be considered in remedy selection, HCFA has not emphasized this factor. Thus, it is correct that, under current application of HCFA's rules, previously terminated nursing homes are able to re-enter the Medicare or Medicaid programs with a "clean slate" relative to past performance and, as such, are treated less aggressively than

other facilities for which termination did not become necessary. In order to eliminate the enforcement-related advantages that previously terminated facilities currently enjoy upon re-entry, we agree with GAO that pre-termination performance ought to be a factor in how that facility is treated subsequently upon re-entry. We will make explicit in our manual that these facilities will automatically be subject to immediate sanctions upon subsequent findings of noncompliance. States and HCFA regional offices track termination information, and we will work to ensure that the information is used systematically when subsequent enforcement actions are considered. We will further consider applying this policy to previously terminated homes that re-enter under new ownership.

GAO Recommendation

Improve the referral process. The Administrator should revise HCFA guidance so that States refer homes to HCFA for possible sanction (such as CMPs) if they have been cited for a deficiency that contributed to a resident's death.

HCFA Comment

We concur. It should be noted that States have authority to make their own remedy determinations and, unless otherwise mandated, such determinations are at their discretion. However, current guidelines authorize referral and imposition of CMPs for egregious violations, such as those that contribute to a resident's death, even if the problem has been corrected. In addition, the new CMP regulation we announced last July will give States the additional option of recommending fines for specific incidents, such as an instance of abuse or neglect that contributed to a resident's death. This would be an additional tool to address situations such as those cited in the report where a resident suffers harm due to a serious violation that is then quickly corrected. The cases cited by the GAO where referrals were made are disturbing and we need to reiterate to States that, under current law, there is a remedy for cases of past noncompliance and they should use it in appropriate situations. As we develop more comprehensive information systems, we will request that States report to HCFA when deaths occur for which no CMP is being imposed.

GAO Recommendation

Develop better management information systems. The Administrator should enhance OSCAR or some other information system that can be used both by the States and by HCFA to integrate the results of complaint investigations, track the status and history of deficiencies, and monitor enforcement actions.

HCFA Comment

We concur. We are undertaking a major redesign of these systems. Because this is a long-term project and because we must prepare to meet the Y2K computer challenge, we will soon be making some interim improvements to the current enforcement data system that will make the system more useful to the States and our Regional Offices as well as allow us to better monitor the enforcement actions. Secondly, software being implemented in July, 1999 will provide for a more user-friendly environment for tracking the status and history of deficiencies at the State level. This software will also automate the current requirement for collection by States of ownership information.

Although our current system provides for collection of survey information based on complaints for failure to meet federal requirements, States do not consistently report complaint data through this system. We will redirect States to adhere to federal requirements for reporting this information. However, many States have complaint investigation systems that exceed federal requirements and we have no authority to require that these data are reported to HCFA.

As we redesign our management information system we will revise the complaint module to assure that these data are fully integrated with the other information on facility performance.



Office of the Administrator
Washington, D.C. 20201

MAR 2 1999

To: June Gibbs Brown
Inspector General

From: Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

Subject: Office of the Inspector General Draft Reports: "Long-Term Care
Ombudsman Program: Overall Capacity"; and "Long-Term Care
Ombudsman Program: Complaint Trends."

I very much appreciate the opportunity to review and comment on these two draft reports that examine trends in Ombudsman complaints and describe the overall capacity of State Long Term Care Ombudsman programs to promote and monitor the quality of care in nursing homes.

Last July, the Clinton Administration unveiled an aggressive comprehensive initiative to ensure that all nursing homes comply with federal standards for the delivery of quality care. Since that time, we have made progress in strengthening nursing home inspection systems and cracking down on nursing homes that repeatedly violate safety rules. In addition, the Administration has taken other steps to reduce the incidence of bed sores, dehydration and malnutrition in nursing homes and to give consumers ready access to comparative information about nursing-home quality. HCFA also has implemented a new system to oversee the States, which have primary responsibility for conducting on-site inspections and recommending sanctions against poor-quality nursing homes. However, HCFA and state agency survey staff cannot be in every nursing home in every state continually monitoring care at all times.

For this reason, President Clinton specifically has called for the reauthorization of the Older Americans Act, which includes the Ombudsman program. Though Ombudsmen lack enforcement and regulatory oversight authority, their function is absolutely critical in maintaining quality care in nursing homes. In making regular visits to nursing homes and acting as advocates for residents, the Ombudsmen frequently are the source of complaint investigations that HCFA and the state survey agencies follow up on. The Ombudsmen are clearly an important partner for HCFA in our mutual goal of enforcing nursing home standards and ensuring that all nursing home residents are treated with dignity and compassion.

Though progress has been made in improving the quality of care in nursing homes, we need to continually build upon it. To this end, HCFA is willing to work with the Administration on Aging (AOA) to increase their effectiveness and to facilitate communications between AoA and State survey agencies to better serve nursing home residents.



DEPARTMENT OF HEALTH & HUMAN SERVICES

The Administrator
Washington, D.C. 20201**DATE:** MAR 2 1999**TO:** June Gibbs Brown
Inspector General**FROM:** Nancy-Ann Min DeParle
Administrator

NMD

SUBJECT: Office of Inspector General (OIG) Draft Report: "Public Access to Nursing Home Survey and Certification Results," (OEI-06-98-00280)

I appreciate the opportunity to review and comment on this draft report that discusses the availability and usefulness of nursing home survey results to the public. I am pleased to see that the report acknowledges the Health Care Financing Administration's (HCFA's) new Internet site, Nursing Home Compare, as a source of providing summary nursing home survey results. More and more Americans, including seniors, use the Internet, and many more have access through their children and grandchildren, their advocates, and others who help them make decisions about their health care. But it is just one part of our efforts to make useful information available to beneficiaries, their families and the public.

Making survey results more accessible fits into our broader consumer-education strategy, which includes the National Medicare Education Program and the enhancement of our consumer Internet site, www.medicare.gov. Additionally, we are developing public awareness campaigns which address most of this report's recommendations.

As you know, improving the quality of care for nursing home residents remains a top priority for this administration. In 1995, the Clinton Administration implemented the toughest-ever enforcement regulations, which resulted in measurable improvements in the quality of care in our nation's almost 17,000 nursing homes. Building on that foundation, the President announced an aggressive new initiative in July 1998 to further strengthen oversight of the state enforcement efforts and to ensure that all nursing home residents receive the quality care they deserve and their families expect.

We have already implemented many aspects of this initiative, including the creation of Nursing Home Compare, which allows consumers to obtain and compare nursing-home survey results in an easy-to-use format. We also have issued new guidance to states to

Page 2 - June Gibbs Brown

strengthen their nursing home inspection systems and to crack down on nursing homes that repeatedly violate safety rules. We have taken other steps to reduce the incidence of bed sores, verbal and physical abuse, dehydration and malnutrition. And the President's Fiscal Year 2000 budget request includes additional resources to fully implement all aspects of the initiative.

Our specific comments follow:

OIG Recommendation #1

HCFA should continue to promote public awareness of the required quality of care standards for nursing homes.

HCFA Response

We concur. HCFA has taken a series of steps to help the public know more about quality standards for nursing homes and to ensure that states enforce those standards effectively. These steps also include the nursing home initiative's campaigns of improving quality of care by focusing on nutrition, hydration, and prevention of abuse, and pressure sores.

OIG Recommendation #2

HCFA should work with states and patient advocacy associations to promote public awareness that nursing home survey results are available for review by any member of the public.

HCFA Response

We concur. We are working with our partner organizations to promote public awareness regarding access to HCFA survey reports on nursing homes. HCFA provides information to over 200 organizations which include advocacy groups, corporations, unions, and professional and trade organizations that have direct contact with beneficiaries. Our partners have been informed of the format and content of the Nursing Home Compare database, which serves as HCFA's public resource for nursing home survey results. In addition, the database includes language referring consumers to their state survey agency for the complete survey (HCFA-2567). We are also taking steps in cooperation with the state survey agencies to ensure that each nursing facility complies with requirements for posting survey results for public inspection.

The database went live in October 1998, and it has received about roughly 150,000 page views each month. Since then, we've modified the site to make it easier to use and will continue to take steps to increase public awareness and incorporate public comments.

Page 3 - June Gibbs Brown

OIG Recommendation #3

HCFA should include in its Guide to Choosing a Nursing Home, language that explains simply what constitutes a nursing home survey and the availability and location of survey results.

HCFA Response

We concur. HCFA is currently working on several projects pertaining to the nursing home survey process. For example, we are updating the Guide to Choosing a Nursing Home which includes language about where to find the latest survey results in nursing homes and an explanation of the scope and severity measures in the context of our determination of deficiencies. The Guide is in final draft and expected to be printed in May 1999. The Guide will be distributed to the state health insurance programs, regional offices, libraries, and others upon request. **It also will be available on the Internet.**

Also, HCFA is developing a video titled "What to Look for in a Nursing Home." The video will describe the survey process and how families and others can use survey results in choosing a nursing facility. When it is completed this spring, the video will be distributed to the area agencies on aging, advocacy groups, Social Security Administration (SSA), and others upon request.

Furthermore, we developed a nursing home brochure that includes a section on where to get more information about the performance of facilities. It explains how consumers can obtain survey results from the Nursing Home Compare database and the state survey agencies.

OIG Recommendation #4

HCFA should work with interested public and private entities to promote public knowledge about how and where to access HCFA survey reports on nursing homes.

HCFA Response

We concur. As stated in recommendation #2 above, we are working with our partner organizations to promote public awareness on how and where to access HCFA survey reports on nursing homes. HCFA provides information to over 200 organizations which include advocacy groups, corporations, unions, and professional and trade organizations that have direct contact with beneficiaries. Our partners have been informed of the format and content of the Nursing Home Compare database. This database serves as HCFA's public resource for nursing home survey results, and also includes language referring consumers to their state survey agency for the complete survey (HCFA-2567).

Page 4 - June Gibbs Brown

In addition, we post news items for our partners that pertain to the database on the partner website.

As indicated in recommendation #2 above, the database went live in October 1998, and has received about 150,000 page views each month.

OIG Recommendation #5

HCFA should work with the states, patient advocacy associations, and nursing home industry associations to develop acceptable laymen's language for HCFA nursing home reports provided in response to public requests for such information. Some improvements can be made by modeling a summary report after the one that appears on HCFA's new Internet page.

HCFA Response

We concur. The regulatory statements that serve as the basis for the Federal deficiency tags on the survey report (HCFA-2567) are written using the HCFA Principles of Documentation. These principles (writing rules), were created to provide surveyors with deficiency documentation language that can be applied and interpreted consistently across the country. Without such guidelines in preparing deficiency documentation on the HCFA-2567, there would be differences in language and descriptors nationwide that would make comparisons of deficiencies more difficult and subject to misinterpretation. We agree that, while the use of technical language on the HCFA-2567 better ensures that a facility gets a clear, specific explanation of the deficiencies detected (and thus has no misunderstandings about what is being said) and provides a legally sufficient justification under later legal scrutiny, it is not easily used by the nursing home resident, a family member, or perspective customers looking to make fully informed decisions about the facility. We will work with patient advocacy groups, the states, and nursing home provider associations in order to determine available methods for communicating facility related survey information to this audience in a more easily understood manner. We will also work to identify the methods and resources necessary to move forward in providing this information in a manner that does not compromise the survey and certification tools required to properly ensure Federal enforcement.

OIG Recommendation #6

HCFA should consider the feasibility of requiring nursing homes to provide a HCFA-prepared summary survey report as part of the admission process in each nursing home.

HCFA Response

We concur. We will explore with our partners and stakeholders the various dimensions (regulatory, financial, legal, and enforceability) of this recommendation.

Page 5 - June Gibbs Brown

OIG Recommendation #7

HCFA should promote awareness of the new HCFA Internet site providing summary nursing home survey report information.

HCFA Response

We concur. HCFA continues to refine and improve this very informative and useful website, using input received from area focus groups of seniors and their families, and other comments from the public. We have made senior and advocacy groups, the press, and Congress aware of the site, and will continue to make sure the public knows about it.

OIG Recommendation #8

HCFA should create a direct link to the summary nursing home information on HCFA's Internet home page.

HCFA Response

We concur. We have now established a direct link from HCFA's websites -- www.hcfa.gov and www.medicare.gov -- to the Nursing Home Compare site and are exploring other common sense "hotlink" connections. These links will make the information easily accessible by virtually anyone looking for the site.

OIG Recommendation #9

HCFA should require the posting of available nursing home survey information in a standard, readily visible location in each nursing home.

HCFA Response

We concur. While HCFA has required that the nursing home survey information should be accessible, we agree it should be posted in an accessible public location where it could be seen by anyone wishing to see the last survey findings. We will emphasize compliance with existing requirements and insist that State surveyors enforce them.

OIG Recommendation #10

HCFA should enforce the requirement to post survey results in locations not readily observable by nursing home staff.

HCFA Response

We concur with the intent and will strive to emphasize public placement that is openly accessible. In creating such a location, we must be careful not to put frail residents at risk by encouraging them to leave the sight of their caregivers.

Page 6 - June Gibbs Brown

OIG Recommendation #11

HCFA should explore other avenues of providing nursing home information to the public. For example, determine the feasibility of providing hospital discharge planners with nursing home survey reports to facilitate the choice of a nursing home when patients are transferred from the hospital to a nursing home.

HCFA Response

We concur. HCFA already instructs the states to send information to the ombudsmen and SSA district offices. HCFA will explore ways to provide information to hospital discharge planners.

OIG Recommendation #12

HCFA should work with states and advocacy associations in order to explore additional means of providing nursing home profile information.

HCFA Response

We concur. We are meeting with advocacy groups regarding the nursing home enforcement initiative. In addition, HCFA's Provider Enrollment and Chain Ownership System will capture additional information about facility ownership that will be accessible through HCFA's website. HCFA plans to add additional information to the website, and will seek input from the public, states, advocacy groups, and associations.

Additional Comment

One suggestion not in the OIG report is the development of a national 1-800 number to access information and reports.

HCFA will explore this idea and will identify public information access options that may be made available and the financial impact of providing such a service.

We also believe that HCFA information on nursing home choices should indicate that home and community-based services are frequently an alternative to nursing homes or other long-term care institutional facilities. This is consistent with HCFA instructions to state agencies, and is an integral part of the Medicaid waiver process.

Office of the Administrator
Washington, D.C. 20201

DATE: FEB 10 1999

TO: June Gibbs Brown
Inspector General

FROM: Nancy-Ann Min DeParle *Nancy-Ann DeParle*
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Reports: "Nursing Home Survey and Certification - Overall Capacity," (OEI-02-98-00330) and "Nursing Home Survey and Certification - Deficiency Trends," (OEI-02-98-00331)

We appreciate OIG's efforts to assist us in addressing the State survey and certification programs' capacity to monitor quality of care in nursing homes. The reports echo our own concerns and underscores the need for our on-going efforts to help states to improve enforcement efforts, make surveys less predictable, ensure adequate staff resources and promote better coordination with Ombudsmen. In fact, HCFA has already begun implementing a number of your recommendations.

In 1995, the Clinton Administration implemented the toughest-ever enforcement regulations, which resulted in measurable improvement in quality of care in nursing homes. Building on that foundation, the President announced an aggressive new initiative in July 1998 to further strengthen enforcement and to ensure that all nursing home residents receive the quality care that they deserve and their families expect.

We have already implemented many aspects of the initiative. We have issued new guidance to States to strengthen their nursing home inspection systems and to crack down on nursing homes that repeatedly violate safety rules. We have also taken other steps to reduce the incidence of bed sores, dehydration and malnutrition, and to give consumers ready access to comparative information about nursing home quality. The President's Fiscal Year 2000 budget request includes additional resources to fully implement all aspects of the initiative.

I am pleased to see that the reports acknowledge that our on-going initiative addresses many of the OIG's findings. Ultimately, we want all residents of nursing homes to be treated with compassion and dignity. Our efforts to date represent a major step in that direction, and we will continue to work with the states, providers and advocates to better protect our most vulnerable citizens.

Our specific comments follow:

"Nursing Home Survey and Certification - Overall Capacity," (OEI-02-98-00330)

OIG Recommendations #1 - 5

The following OIG recommendations support HCFA's initiative to strengthen the enforcement efforts:

- making surveys more timely and effective,
- changing the survey schedule to make surveys more unpredictable,
- increasing the number of night and weekend surveys.
- increasing the number of surveys at nursing homes with chronic quality of care problems, and
- focusing on specific problems such as pressure sores, dehydration, and malnutrition.

HCFA Response

We concur. The above recommendations are part of HCFA's nursing home initiative which was developed in July 1998 in response to HCFA's Report to Congress. Implementation of these recommendations is well underway.

OIG Recommendation #6

HCFA should evaluate the surveyor staffing in each State to assure that adequate staffing is available to complete all standard surveys, follow up surveys, and respond to complaints.

HCFA Response

We concur. In fact, we do review state surveyor staffing as part of the survey and certification budget process, and we will be examining these data more closely as part of our effort to determine whether states are complying with the requirements of the contractual agreement they enter into with HCFA to perform these activities. We note, however, that surveyor staffing levels are directly dependent upon Congressional funding. Currently, even with the increased appropriations we have received to fund the survey and certification program, we must allocate carefully and phase in the implementation of some of the pieces of the nursing home initiative. We look forward to working with the Congress as we evaluate surveyor staffing needs.

OIG Recommendations #7 - 9

HCFA should:

- provide additional training to State surveyors
- provide a forum for State surveyors to meet and discuss common issues
- facilitate better coordination with the Ombudsman program

HCFA Response

We concur. These issues are being addressed by the new Federal Monitoring System (FMS). The FMS was implemented on September 30, 1998 and, through our regional offices, we are beginning to receive feedback from states on the new process. We will use that feedback to guide our training and coordination efforts.

"Nursing Home Survey and Certification--Deficiency Trends," (OEI-02-98-00331)

OIG Recommendations #1 - 5

The following OIG recommendations support HCFA's initiative to strengthen the enforcement efforts:

- making them more timely and effective,
- changing the survey schedule to make surveys more unpredictable,
- increasing the number of night and weekend surveys.
- increasing the number of surveys at nursing homes with chronic quality of care problems, and
- focusing on specific problems such as pressure sores, dehydration, and malnutrition.

HCFA Response

We concur. The above recommendations are part of HCFA's nursing home initiative which the President announced in July 1998 as the Administration's initial response to HCFA's Report to Congress outlining the strengths and weaknesses of the 1995 regulations. Implementation of these recommendations is well underway.

OIG Recommendation #6

HCFA should develop staffing standards for registered nurses and certified nurse assistants in nursing homes to assure sufficient staff on all shifts to enable residents to have proper care. Staffing standards should account for the intensity of care needed, qualifications of the staff, and the specific characteristics of both the nursing home and the residents.

HCFA Response

We concur that many of the problems that we have identified, and that the OIG and the GAO have identified, appear to be related to inadequate staffing or ineffective training of staff. In the early 1990's, Congress requested that HCFA prepare a report studying the relationship of staffing levels to the quality of care nursing home residents receive. That report was never developed. Last summer, the Administrator directed HCFA staff to undertake this effort, and in September 1998 a contract was awarded to Abt Associates to assist us in completing a comprehensive nurse staffing study. Current plans call for the analyses to be completed and a report delivered to HCFA by October 1999, and then submitted to Congress by the end of the year.

This comprehensive nurse staffing study will help HCFA determine if minimum nurse staffing ratios are appropriate, and should address the issue of staff qualifications the OIG has identified. The potential cost and budgetary implications of minimum ratio requirements will also be studied.

LEVEL 1 - 2 OF 283 STORIES

Copyright 1999 Cox News Service
Cox News Service

March 18, 1999

SECTION: Washington - general news

LENGTH: 692 words

HEADLINE: CONDITIONS IN NURSING HOMES MAY BE WORSENING

BYLINE: JULIA MALONE

DATELINE: WASHINGTON

BODY:

A quarter of the nation's nursing homes have severe health and safety infractions that often go unpunished, although the conditions jeopardize residents, federal auditors said Thursday.

Their study concluded that federally mandated surveys of the nation's 17, 000 nursing homes indicate conditions have not improved _ and may have worsened _ since 1995.

Concentrating on problem nursing homes in four states, the report found that fines were rarely collected and sanctions were usually blocked by appeals that took years.

"The government is not doing enough," said Sen. Charles Grassley (R-Iowa) chairman of the Senate Special Committee on Aging, as he released the study, which was conducted by the General Accounting Office, the investigative arm of Congress.

"Patients suffer and taxpayers are suckers," he said. He cited one case in which a **nursing home** resident wandered off and was found days later, stabbed to death. "The **nursing home** had never reported the person missing."

Texas had some of the worst cases in the study, which cited one **chain** that had 72 civil fines imposed on it totalling more than \$4.1 million. Yet the **chain**, identified by state and federal officials as Texas Health Enterprises, Inc., has paid only \$120,000, according to logs provided by the Texas Department of Human Services. The rest of the penalties, involving at least 62 cases going back to 1995, have been appealed.

The largest **chain** in the state, Texas Health Enterprises owned about 11 percent of its **nursing homes** during the period of the study, but accounted for more than 18 percent of enforcement actions for health and safety infractions.

Moreover, **problems** with the Texas-based **chain** extended to Michigan, where six of its facilities were the targets of 27 separate enforcement actions.

Stephen Moors, a spokesman for Texas Health Enterprises, had no immediate



LEXIS·NEXIS®

Ⓜ A member of the Reed Elsevier plc group



LEXIS·NEXIS®

Ⓜ A member of the Reed Elsevier plc group



LEXIS·NEXIS®

Ⓜ A member of the Reed Elsevier plc group

Cox News Service, March 18, 1999

comment on the findings.

The General Accounting Office survey, which also looked at California and Pennsylvania, found enforcement of regulations to be lax throughout. Nursing homes frequently corrected **problems** to escape fines, only to be cited for the same **violation** later in what the report called a "yo-yo" effect.

In one case, the study cited an unidentified Texas home that was cut off from Medicare payments for six months after a string of **violations**. Five months after payments resumed, state surveyors found new **problems**, including bed sores and malnutrition.

"The threat of sanctions appeared to have little effect," said the report, in part because of a backlog of some 700 cases in the appeals process that must be completed before penalties are collected.

Anticipating the critical report, the Health Care Financing Administration, which regulates nursing homes, announced earlier this week that it would toughen penalties and direct states to speed up investigations of complaints.

California, Michigan and Pennsylvania have endorsed the GAO findings and promised to cooperate. Texas has offered no formal response.

"We're working on a system" to improve nursing home care, said Rosemary Patterson, spokeswoman for the Texas Department of Human Services.

Marie Wisdom, founder of Texas Advocates for Nursing Home Reform, expressed doubt about a quick fix.

"Bad homes are paid the same as good ones," she said, adding that operators have no incentive to offer top quality care. She said that nursing home companies "pocket profits and then put money into political action committees and lobby the government."

The chairman of the Senate aging committee offered few assurances that nursing homes would improve. "I intend to do my oversight responsibility to make sure the laws are enforced," Grassley said.

But he added that he's encouraging the public to be careful consumers by inspecting the records of nursing homes with state agencies and by using a federal Internet web site (www.medicare.gov) (cq) for comparisons.

He urged "visiting with residents and the family of residents" before picking a nursing home, and then visiting loved ones frequently.

"People that are visited have a higher quality of life," he said.

ENDIT

LANGUAGE: ENGLISH

LOAD-DATE: March 19, 1999



LEXIS·NEXIS®

Ⓜ A member of the Reed Elsevier plc group



LEXIS·NEXIS®

Ⓜ A member of the Reed Elsevier plc group



LEXIS·NEXIS®

Ⓜ A member of the Reed Elsevier plc group

LEVEL 1 - 39 OF 283 STORIES

Copyright 1999 Knight Ridder/Tribune Business News
Copyright 1999 Lexington Herald-Leader
LEXINGTON HERALD-LEADER

January 23, 1999, Saturday

KR-ACC-NO: LX-NURSING

LENGTH: 576 words

HEADLINE: CEO, Chairman Leaves Louisville, Ky.-Based Nursing-Home Operator

BYLINE: By Amy Baldwin

BODY:

Louisville's Vencor Inc. announced late yesterday that co-founder W. Bruce Lunsford had resigned as chairman of the board and chief executive officer.

The company also announced the appointment of Edward L. Kuntz as new chairman and CEO.

Yesterday marked the second time Kuntz replaced a Vencor founder. Kuntz joined Vencor in November as president and chief operating officer when co-founder and COO Michael Barr resigned.

Kuntz, a lawyer by training, has 20 years of experience in long-term health administration and consulting. From 1992 to 1997, he served as chairman and CEO at Living Centers of America until it merged with Apollo Management and GranCare Inc. Under Kuntz's direction, Living Centers' annual revenue grew from \$ 350 million to \$ 1.2 billion.

"The company had obviously put in place the management team they were much more confident in regarding the operation of the nursing homes," said Charles Lynch, an analyst at Schroder & Co.

Vencor confirmed that Lunsford is stepping aside to let other executives with more experience in the nursing-home industry lead Vencor. He will remain chairman of Ventas Inc., a real estate company that owns the properties operated by Vencor.

Lunsford's resignation may be another sign of bad times for the company, which is dealing with management turmoil and slumping profits.

Vencor also has been under federal and state investigation for a nursing-home admissions policy that admitted residents covered by generous private insurance or by Medicare while pushing out poorer Medicaid patients. The company reversed its profit-focused admissions policy, and Lunsford issued an apology for evicting Medicaid patients at a handful of homes.

Vencor's selective admissions strategy was such a flop that the company now



LEXIS·NEXIS®
A member of the Reed Elsevier plc group



LEXIS·NEXIS®
A member of the Reed Elsevier plc group



LEXIS·NEXIS®
A member of the Reed Elsevier plc group

cares for fewer private and Medicare-insured patients than it did when it bought a **chain of nursing homes** three years ago. Ironically, Medicaid now accounts for 47 percent of Vencor's **nursing-home** revenue, the highest percentage ever.

Vencor's record of high-quality care is being questioned, too. A Wall Street Journal analysis of government inspection records showed that the number of times Vencor nursing homes have been cited for staff shortages, medication errors or other care **problems** had increased in the last year.

Wisconsin tried in October to close Vencor's largest nursing home, citing the staff's failure to watch over disoriented residents likely to wander off, among other **problems**. Vencor has avoided a shutdown of the 657-bed home in Milwaukee by turning management over to a group of nuns.

Vencor's stock (NYSE: VC) hasn't been faring well. Vencor stock split last year, but the value of the combined shares is less than half that of a single share of Vencor stock in 1995.

It closed at \$ 5 yesterday, up 13Z16 or 19.4 percent.

"I believe we approached the nursing-home industry as a company with a little bit of arrogance and a little bit of naivete," Lunsford said late last year at a conference of securities analysts. "That was a mistake."

Vencor was founded in 1985. Today it operates hospitals, nursing homes and contract ancillary services in 46 states with more than 65,000 employees.

Herald-Leader business reporter Jamie Butters and Bloomberg News contributed to this report.

Visit Kentucky Connect, the World Wide Web site of the Lexington (Ky.) Herald-Leader, at <http://www.kentuckyconnect.com/heraldleader>

LANGUAGE: ENGLISH

JOURNAL-CODE: LX

LOAD-DATE: March 22, 1999



LEXIS·NEXIS®

Ⓜ A member of the Reed Elsevier plc group



LEXIS·NEXIS®

Ⓜ A member of the Reed Elsevier plc group



LEXIS·NEXIS®

Ⓜ A member of the Reed Elsevier plc group

LEVEL 1 - 19 OF 283 STORIES

Copyright 1999 Star-Telegram Newspaper, Inc.
THE FORT WORTH STAR-TELEGRAM

February 21, 1999, Sunday FINAL AM EDITION
Correction Appended

SECTION: METRO; Pg. 5

LENGTH: 853 words

HEADLINE: Experts recommend families investigate nursing homes;
Sensitive Care's troubles raise concerns about other facilities in the state.

BYLINE: Mitch Mitchell, Star-Telegram Writer

BODY:

This month's forced exodus of elderly residents from two homes in the Sensitive Care chain triggered concerns about the stability of nursing homes in Texas.

Boulevard Manor Care Center in Richland Hills closed last week, and the remaining 24 residents in Colonial Manor Nursing Center in Fort Worth are expected to move out tomorrow. Both homes were among 13 taken over by the state because of Fort Worth-based Sensitive Care Inc.'s financial problems.

"The residents of the affected nursing homes are really in quite a state," said state Rep. Vicki Truitt, R-Keller. "They are only innocent victims. The incident has been a real wake-up call for the Legislature about paying close attention to who is in this business. "

State regulators say they believe that other Texas nursing homes are having financial problems, but they have no way to determine how many.

"I can guarantee there are other homes in this same situation that HCFA Health Care Financing Administration is looking at," said Rosemary Patterson, spokeswoman for the long-term-care regulatory division of the Texas Department of Human Services.

Signs of an impending financial failure are difficult for the public to spot, but warning signs usually are evident when a nursing home has deficiencies in residential care, said Laura Lee Harris, Tarrant County Mental Health Association executive director.

She said that concerned family members can contact Tarrant County's ombudsman program, which uses staff members and volunteers to make regular visits to nursing homes and to monitor state reports for information about conditions.

The ombudsman program can provide state inspection reports and complaints against nursing homes. It can recommend appropriate homes,



LEXIS·NEXIS[®]

A member of the Reed Elsevier plc group



LEXIS·NEXIS[®]

A member of the Reed Elsevier plc group



LEXIS·NEXIS[®]

A member of the Reed Elsevier plc group

advise patients of their rights and put people in touch with volunteers who regularly visit nursing homes.

Staff ombudsman Craig Pomykal said that if someone had asked him three months ago about placing a family member at Boulevard Manor Care Center, he would have told them about complaints registered against the nursing home. He said he also would have mentioned problems that were identified by the state during its last inspection.

"There were a number of pretty substantial deficiencies dealing with nursing care," Pomykal said.

He also could have gotten a state report on the nursing home that is available from the Internet.

Patient advocates said that those concerned about the well-being of a relative should make regular visits to their nursing home to look, listen and smell:

- * Look at residents' fingernails to get an idea of how staff members are caring for residents.

- * Listen to how staff members talk to one another and to residents for an idea of how residents are being treated.

- * And smell - the home should not have unpleasant odors.

"You have to trust your instincts," Harris said.

Beth Ferris, president of Texas Advocates for Nursing Home Residents, said her group believes that there is strength in numbers.

She recommends that families of residents band together to serve as watchdogs.

"We can't continue to put frail, elderly people through this kind of trauma," Ferris said. "We've got to get to this kind of thing before it gets that far. "

In 1997 more than 7,600 people were in 165 long-term nursing facilities in Tarrant County, according to the Mental Health Association of Tarrant County.

The state's senior citizen population is expected to double during the next 25 years, and the number of people 85 and older is expected to double between 2000 and 2010, studies show.

State Rep. Elliott Naishtat, D-Austin, wants to introduce legislation that would help prevent the financial troubles that Sensitive Care had.

The state took over the 13 Sensitive Care nursing homes this year after federal investigators, suspecting Medicare fraud, shut off the chain's Medicare funding.



LEXIS·NEXIS®

Ⓜ A member of the Reed Elsevier plc group



LEXIS·NEXIS®

Ⓜ A member of the Reed Elsevier plc group



LEXIS·NEXIS®

Ⓜ A member of the Reed Elsevier plc group

Three bills that Naishtat's office is drafting would require nursing home operators to submit annual financial statements to the state, to provide adequate financial resources to meet expenses, to be bonded and to create criminal penalties for nursing home owners who default on their financial obligations.

"Realistically speaking, this could happen again. And I would hope the state would be better prepared for it," Naishtat said.

Mitch Mitchell, (817) 685-3807

Who to contact about nursing home care

LONG-TERM CARE OMBUDSMAN

State: (800) 252-2412

Tarrant County: 335-5405

RESIDENTS' RIGHTS

Texas Department of Human Services, long-term-care regulatory division, (800) 458-9858

COMPLAINTS

Texas Protective and Regulatory Services: (800) 252-5400

Tarrant County: 735-9381, Ext. 2064

TO REPORT SUSPECTED ABUSE, NEGLECT

Texas Department of Human Services: 625-2161

Area Agency on Aging of Tarrant County: 258-8081

LEGAL ADVICE

Texas attorney general's office, medicaid fraud: (512) 463-2011

U.S. office of inspector general: (800) 447-8477

FOR INTERNET REPORTS ON NURSING HOMES

www.medicare.gov/nursing/report.asp

CORRECTION-DATE: February 24, 1999

CORRECTION:

Those who want to complain about nursing home care should call (800) 458-9858. The telephone number is incorrect in this story.

LANGUAGE: ENGLISH

LOAD-DATE: March 2, 1999



LEXIS·NEXIS®

Ⓜ A member of the Reed Elsevier plc group



LEXIS·NEXIS®

Ⓜ A member of the Reed Elsevier plc group



LEXIS·NEXIS®

Ⓜ A member of the Reed Elsevier plc group

LEVEL 1 - 50 OF 283 STORIES

Copyright 1998 Journal Sentinel Inc.
Milwaukee Journal Sentinel

December 26, 1998 Saturday Final

SECTION: News Pg. 3

LENGTH: 411 words

HEADLINE: New management at nursing home faces deadline
Administrator at Mount Carmel says changes are being made to ensure positive inspection

BYLINE: DAVE UMHOEFER

SOURCE: Journal Sentinel staff

BODY:

The new management team at Mount Carmel Health and Rehabilitation Center is "working feverishly" to meet a Jan. 29 deadline to bring the nursing home up to government-set care standards, according to interim administrator Dick Rau.

"There are a number of broken systems" related to care delivery and staff communication that need fixing, said Rau, who is also chief executive officer of Clement Manor nursing home in Greenfield.

Another major issue for the new managers is an existing contract with nurses aides that some employees say could lead to an exodus of staff in the new year if planned cuts in benefits are not stopped.

"If that happens, it's trouble," Rau said about possible staff departures.

But the issue is complicated because the labor contract between nurses aides and Vencor Inc., the national chain that owns Mount Carmel, covers seven Wisconsin nursing homes, including Mount Carmel. Rau said he hoped some resolution could be reached before year's end.

Rau praised the dedication of the nursing staff and said morale was good.

"That's still the strength," Rau said.

It was a severe shortage of nurses aides that contributed to serious care problems at Mount Carmel this year. State and federal regulators issued dozens of care citations, as well as \$750,000 in fines, and are on the brink of cutting off crucial Medicaid and Medicare funding that would likely force the Greenfield home's residents to move.

To avert the cutoff, Vencor agreed to turn over the home, which is at 5700 W. Layton Ave., this month to a new management team that includes Clement Manor and the Minnesota-based Benedictine Health System, with assistance from Covenant Healthcare of Milwaukee. But the home still has to prove that it can provide good care.



LEXIS-NEXISTM
A member of the Reed Elsevier plc group



LEXIS-NEXISTM
A member of the Reed Elsevier plc group



LEXIS-NEXISTM
A member of the Reed Elsevier plc group

Rau said a long-term goal for the home is to reduce reliance on temporary nurses aides, so-called pool help. He estimated that about one in three aides working at the 657-bed home was hired from a pool.

The home, Wisconsin's largest nursing facility, has 440-plus residents, down substantially from more than 600 last year.

Nurse staffing levels are very good right now, Rau said.

State and federal inspectors are expected to return for an unannounced inspection sometime in January.

Rau said he was hoping it would not be a one-shot deal in which the home was given no chance to make immediate corrections before Jan. 29 if care violations are found.

LOAD-DATE: December 27, 1998



LEXIS·NEXIS®

Ⓜ A member of the Reed Elsevier plc group



LEXIS·NEXIS®

Ⓜ A member of the Reed Elsevier plc group



LEXIS·NEXIS®

Ⓜ A member of the Reed Elsevier plc group

LEVEL 1 - 63 OF 283 STORIES

The Associated Press State & Local Wire

The materials in the AP file were compiled by The Associated Press. These materials may not be republished without the express written consent of The Associated Press.

November 16, 1998, Monday, BC cycle

SECTION: State and Regional

LENGTH: 583 words

HEADLINE: Probe finds corporate chains increasingly running nursing homes

DATELINE: TAMPA, Fla.

BODY:

About 20,000 people live in Florida nursing homes run by six public companies, but quality care may not be mixing with the need to show investors a profit.

While workers tend their jobs out of love, many bosses place a priority in satisfying investors and demands for profits, according to a six-month investigation by The Tampa Tribune.

The nursing home industry, once a collection of individual operations, is becoming dominated by large companies. The top six companies care for one third of the state's nursing home residents, most of whom can't dress themselves and half of whom need help eating.

State and federal records show business profits can come at a high human cost, the Tribune reported.

Mary Johann died at Wellington Specialty Care and Rehabilitation Center of Tampa, when her neck became pinned between a mattress and bed rail. She was also stuck 10 days earlier, but a worker found her in time.

Her death came three days after the nursing home's corporate leaders told shareholders profits were up because cost controls were so tight.

About one-quarter of Florida's **nursing homes** fell below state standards during inspections between January 1997 and March 1998.

Among four of the state's six major **chains** - Beverly Enterprises Inc., Integrated Health Services Inc., Vencor Inc. and Mariner Health Group Inc. - the substandard rate was 32 percent to 40 percent.

Federal data show the **chains** had higher-than-average rates of reported neglect and abuse, as did many smaller companies with publicly traded stock.

Only one had substantially lower rates: Health Care & Retirement Corp., which



LEXIS·NEXIS[™]

Ⓜ A member of the Reed Elsevier plc group



LEXIS·NEXIS[™]

Ⓜ A member of the Reed Elsevier plc group



LEXIS·NEXIS[™]

Ⓜ A member of the Reed Elsevier plc group

recently merged with Manor Care. **Nursing homes** not tied to shareholders can also have **problems**, but government data shows their overall care is better.

"All you have to do is look at the nonprofits to see what's happening," said Jean Venturino, a visiting nurse who sees patients in several nursing homes. Nonprofits generally show a greater ethic of caring, she said.

Nursing homes can make money and still provide quality care, said Scott Bell, who runs Delta Health Group of Pensacola. The company operates 30 nursing homes in three states and has a lower than average deficiency rating.

The company is successful because it doesn't have to convince stock analysts its a winner, Bell said. It needs to make a profit, but can invest in training and long term goals, he said.

"Investors look at the short term. Investors look at returns and dividends. They're not looking at quality of care," Bell said.

"Everyone in this business is trying to do a good job," said Stephen Guillard, chief executive of Harborside Healthcare, a private corporation in Boston that owns nine homes in Florida.

Profits aren't as high as many people think, Guillard said. Government payments are shrinking, more residents have complex illnesses and workers are hard to find.

Shrinking government payments have depressed nursing home stocks and piqued analysts' concerns. They want signs companies can adjust to a new payment system and keep profits growing.

Tougher nursing home scrutiny is warranted because patients tend to be frail, said Gilda O'Brien, a former nursing home activities and marketing director in St. Petersburg.

But neglect is not the industry's only problem. There's a lack of warmth when a home is understaffed or has rapid employee turnover, O'Brien said.

"We've figured out all these ways to keep people alive," O'Brien said. "Now do we just forget them?"

LANGUAGE: ENGLISH

LOAD-DATE: November 16, 1998



LEXIS[®]·NEXIS[®]

A member of the Reed Elsevier plc group



LEXIS[®]·NEXIS[®]

A member of the Reed Elsevier plc group



LEXIS[®]·NEXIS[®]

A member of the Reed Elsevier plc group

LEVEL 1 - 54 OF 283 STORIES

Copyright 1998 The Tribune Co. Publishes The Tampa Tribune

The Tampa Tribune

December 22, 1998, Tuesday, FINAL EDITION

SECTION: BAYLIFE, Pg. 3

LENGTH: 609 words

HEADLINE: Nursing home solutions start at the top;

BYLINE: Lindsay Peterson;

BODY:

Everyone who has ever written about older people or social services in general has received those calls from irate, frustrated, bereft people with a parent or spouse in a nursing home.

And most of us have written the horror stories about people who are bludgeoned by a demented resident or left to waste away in their beds. Always people ask: Was the home taking shortcuts on staff or supplies just to save money?

This past spring, however, a different dimension of the profit question arose as we learned about the plans by a company called Vencor to evict its Medicaid residents from a home in Tampa.

These are the poor and impoverished people who depend on the government to pay their nursing home bills. Homes generally receive \$ 100 per day per Medicaid resident, which is far less than what they get from residents with their own money, Medicare coverage or some other insurance.

Vencor is a \$ 3.2 billion company that sells public stock. At the time of the evictions, stockholders were upset because of reports that government health care spending cuts would cut company profits.

This brought up a new question about the effect of stockholder demands on nursing homes.

We took six months to study nursing homes statewide. We found that homes run by large, publicly traded companies had more problems, on average, than nonprofits and homes run by for-profit companies that didn't sell stock.

So, what was it about having stockholders that changed a company's behavior?

The quest for profits seems to be the obvious answer, but it's more complicated than that.

It's not so much that money is siphoned away from patient care. In many cases



LEXIS·NEXIS[®]
A member of the Reed Elsevier plc group



LEXIS·NEXIS[®]
A member of the Reed Elsevier plc group



LEXIS·NEXIS[®]
A member of the Reed Elsevier plc group

it is, but there's another factor. The daily life of a publicly traded company is so intense, as stocks rise and fall minute by minute, the questions of how to nurture workers and care for residents fall by the wayside.

This is particularly true when residents aren't seen as "customers." And for the most part, they're not customers. They're not in a position to get up and walk out if they get bad care.

Middle managers suffocate in this kind of corporate culture.

Turnover among nursing home administrators is alarmingly high, says a recent study by researchers at Andrews University in Berrien Springs, Mich. It's more serious than the industry seems to know, they wrote in the publication "The Gerontologist," produced by the Washington-based Gerontological Society of America.

Overall, 40 percent of the administrators in the study, which focused on Indiana and Michigan, changed jobs at least once a year. The **problem** was worse in homes run by corporate **chains** than in independently owned homes and nonprofits.

This can be devastating to a **nursing home**. Several studies have linked unstable management and poor care.

The administrators were driven away by a variety of things, the Andrews researchers said, but most dealt with not having the freedom to make their own decisions, the demands of their supervisors and differences between their ethics and values and those of the corporation.

"The lessons for multifacility and for-profit corporations are inescapable," the authors wrote.

Build administrators' loyalty and trust. Give them respect and authority.

As my colleagues and I studied the nursing homes in Florida with the worst **problems**, we would see the parade of administrators. In some cases, they stayed less than six months.

We saw that the **problems** in nursing homes go way beyond money, to the core of how corporations operate.

We saw that corporations bring on many of their own troubles.

GRAPHIC: SIGNATURE (C)

TYPE: LINDSAY PETERSON PRIME TIME

LOAD-DATE: December 23, 1998



LEXIS·NEXIS®
A member of the Reed Elsevier plc group



LEXIS·NEXIS®
A member of the Reed Elsevier plc group



LEXIS·NEXIS®
A member of the Reed Elsevier plc group

LEVEL 1 - 94 OF 283 STORIES

Copyright 1998 Little Rock Newspapers, Inc.
The Arkansas Democrat-Gazette

October 04, 1998, Sunday

SECTION: BUSINESS; Pg. BM14

LENGTH: 1780 words

HEADLINE: COVER STORY;

The Beverly Way;

Does the;

nation's largest;

nursing home;

operator put;

profits before;

people?

BODY:

NW EDITION

Beverly Enterprises Inc. has earned a reputation as not only the nation's largest nursing home company, but also as one of the industry's most efficient operators.

But a growing number of critics say that in its drive to increase earnings, the Fort Smith company has increased profits at the expense of patients and employees.

For their part, Beverly executives say the company does a good job of patient care and employee relations. They cite a recent company survey, verified by an independent auditor, finding that more than 92 percent of the chain's patients and their family members are satisfied with living conditions and services.

"If we don't pay attention to the quality of care, we wouldn't have a bottom line to speak of," Beverly spokesman Jim Griffith said. "We are in the business of providing care, and if we don't, we don't have any business."

Former employees and other detractors say the company does, indeed, put profit above all else. In fact, they say that attitude is the essence of what they call "the Beverly Way." They blame this alleged approach for the company's quality-of-care problems, troubled labor relations and even the ongoing federal investigation into possibly fraudulent Medicare billings.

One thing is certain: Whatever Beverly's ways are, they have made for a successful business. For investors, Beverly has become a shining star in the health-care industry. In 1997, the company took in \$ 3.2 billion in revenue and netted \$ 58.6 million.

THE CARE ISSUE

With results like that, one might expect the annual shareholder meeting to be a happy affair -- perhaps a smaller-scale version of Wal-Mart Stores Inc.'s yearly gala. But at Beverly's shareholder meeting in June, one of the more memorable speakers was 14-year-old John Clayton. The teen-ager rose to talk about the condition of the Beverly-owned nursing home his 84-year-old grandfather had been living in for five years.

"Tuesday evening, I saw 14 residents left in the dining room without any staff, a couple still with trays of food, one eating off the trays others had left and one man very wet," John said as he stood before more than 100 investors and



LEXIS·NEXIS®

A member of the Reed Elsevier plc group



LEXIS·NEXIS®

A member of the Reed Elsevier plc group



LEXIS·NEXIS®

A member of the Reed Elsevier plc group

company officials.

In August, the subject of his complaints -- the Neosho Senior Center in Neosho, Mo. -- was slapped with a "notice of noncompliance" for not fixing previously cited **problems**. Missouri's Department of Social Services ordered the home's managers to meet state regulations or have the facility shut down.

State regulators refused to provide specifics on the nature of the **violations**, but they said the center has corrected the **problems** and remains open.

Beverly had quality-of-care **problems** in Texas, a market it abandoned a few years ago with the sale of more than 40 **nursing homes**. Company officials said Texas didn't fit into the **chain's** overall strategy. Most of the homes were in rural markets.

Leslie Henshaw, health-care analyst with ING Baring Furman Selz LLC in New York, said Texas is a difficult state for a **nursing home** operator because of the harsh regulatory climate there. She said the state made it too difficult for Beverly to do business.

"They just couldn't make any money and maintain the quality that I think they wanted," Henshaw said.

"We are not going to let the quality of care suffer because of our concern for the bottom line," Chief Executive Officer David Banks said.

By at least one measurement, the company is doing a better job of patient care than most of its rivals. In 1996, 95.7 percent of Beverly's facilities were in compliance with federal and state health and safety regulations, according to the federal Health Care Financing Administration. The industry average was 94.8 percent.

THE BEVERLY WHAT?

Beverly executives claim ignorance of the term "Beverly Way," although it's a popular topic on Internet stock message boards for the company. When given a definition, some broke into laughter, then flatly denied that the company was concerned only about the bottom line.

When Griffith went door to door at the Fort Smith headquarters asking executives if they knew what the Beverly Way was, he came up empty. "Nobody here seems to have heard of it," he reported back.

But to some observers, the Beverly Way is no mystery -- nor is it a laughing matter. They say virtually every decision is made with one question in mind: What will it mean to the bottom line?

Griffith attributed such allegations to "disgruntled employees and labor unions." Many of Beverly's accusers are politically motivated, he said.

"The labor unions have put out a lot of negative information about us," he said, claiming that the unions spread damaging remarks to the media.

LABOR OFFENSIVE

Beverly has a reputation for fiercely waging battles to the bitter end. Some of its toughest fights have been against organized labor. The nursing home industry is labor-intensive, so if unions negotiate higher wages, they can have a significant impact on earnings.

Beverly has been accused of breaking the law to thwart attempts to unionize its homes, where wages for nurse's aides can be \$ 6 to \$ 7 an hour.

"They are bullies," said Andy Stern, president of the Service Employees International Union.

The National Labor Relations Board has cited Beverly for more than 200 alleged violations in homes across the country. Regulators grouped charges against the Fort Smith company into three major cases, the latest of which was announced in August.

In one state, Pennsylvania, Beverly's history of labor problems stretches back to the 1980s and continues today.



LEXIS·NEXIS[™]
A member of the Reed Elsevier plc group



LEXIS·NEXIS[™]
A member of the Reed Elsevier plc group



LEXIS·NEXIS[™]
A member of the Reed Elsevier plc group

In February 1996, the company fired 350 union employees who had gone on strike at a home in Mount Lebanon. In response, the Service Employees International Union filed a complaint in state court and accused Beverly of using "union-busting" techniques. A Pennsylvania court ruled in favor of the union, but a federal judge overturned the decision.

The company's labor problems were thrust into the national spotlight in May 1997. At a town hall meeting in Pennsylvania hosted by members of Congress, Banks, the Beverly CEO, and other industry executives spoke. But a Cornell University professor made the biggest impression.

Kate Bronfenbrenner said Beverly had a reputation for crushing union-organizing attempts at several of its facilities.

"Beverly fired workers for union activity," she told the audience. She accused the company of illegally changing wages and benefits, spying on workers inside and outside the workplace and bombarding employees with literature "filled with threats, lies and distortions" about what would happen if they were unionized. Her strong words didn't sit well with Beverly, which filed a libel suit. The company dropped the suit because, it said, Bronfenbrenner admitted to certain faults in her research. The professor has denied she admitted to any mistakes. A month ago, federal labor regulators brought another large case. Beverly was ordered to stop anti-union activity at 26 facilities in 15 states. Company officials replied that the government's case was "fundamentally flawed and obviously biased."

Griffith also noted that Beverly has more than 100 contracts with union locals across the country. "We have good relationships with unions."

Beverly executives insist that they want good relationships with their workers. They say they need good, loyal employees to ensure a high quality of care. At least one ex-employee said that was, indeed, the company's philosophy.

"I worked with people who cared about the patients and about the employees," said Bill Ihle, a vice president with Beverly from 1988-92.

MEDICARE INVESTIGATION

Some observers say the ongoing federal investigation into Beverly's Medicare billing practices is plenty of evidence that the company has little regard for how it generates profits.

Investigators are looking into how the nursing home operator may have misallocated federal funds earmarked for labor costs. Details about the scope of the investigation have been sketchy. Company officials say they are cooperating with the government.

On the July day when Beverly announced the investigation, its stock price plunged 35 percent. If agents find evidence of widespread fraud, the effects could be devastating.

Analysts speculate that Beverly has drawn scrutiny from federal investigators and barbs from union organizers because of its sheer size.

"They are the biggest company, and they are a target," said Andrew Gitkin, a vice president and analyst with Salomon Smith Barney in New York. "People see them, and they go after them."

Beverly's officials admit the company has had problems because of its size and rapid growth. It acquired hundreds of homes in the 1980s. It once operated more than 1,900 facilities, from Tokyo to Massachusetts.

"In the long run it wasn't the right thing to do -- for our patients or for our profits," said Boyd Hendrickson, chief operating officer. It was difficult, he said, maintaining standards and controlling the far-flung pieces of its operation.

When Banks took the reins in 1989, the company retrenched. The new chief took steps to reduce its \$ 800 million debt. Beverly sold homes -- it now has 572



LEXIS·NEXIS®

A member of the Reed Elsevier plc group



LEXIS·NEXIS®

A member of the Reed Elsevier plc group



LEXIS·NEXIS®

A member of the Reed Elsevier plc group

facilities -- and found a buyer for its pharmaceutical and acute-care units. "They made a conscious decision to only be in the markets where they could provide quality care, and they wanted to be in the markets where they could make money," Henshaw said.

STILL LOVED ON WALL STREET

In the final analysis, if there is a Beverly Way, there are those who would argue it's the right way.

After downsizing in the past decade, Beverly believes it has improved care at its remaining homes. And profitability has risen in the past few years.

Annual revenue went from \$ 2.8 billion in 1993 to \$ 3.2 billion in 1997. Over the same four years, earnings jumped to nearly \$ 60 million.

The company is bracing for Medicare changes. A new system, to be put in place Jan. 1, encourages nursing home operators to reduce costs of care. Under the new rules, Medicare expects to save \$ 115 billion, while nursing home operators may find themselves struggling to turn a profit.

But health-care experts like Beverly's chances.

"They have slimmed down and are ready for the government's changes," said Richard Lee, health-care services analyst with Hambrecht & Quist LLC in San Francisco.

And so, regardless of what the company's detractors say, Beverly remains a darling on Wall Street. The chain's cost-cutting measures have endeared it to investors. Analysts are holding strong to their belief that the Beverly Way -- regardless of how it is defined -- is the profitable way.

LANGUAGE: ENGLISH

LOAD-DATE: October 11, 1998



LEXIS•NEXIS®

Ⓜ A member of the Reed Elsevier plc group



LEXIS•NEXIS®

Ⓜ A member of the Reed Elsevier plc group



LEXIS•NEXIS®

Ⓜ A member of the Reed Elsevier plc group

LEVEL 1 - 107 OF 283 STORIES

Copyright 1998 PR Newswire Association, Inc.
PR Newswire

September 23, 1998, Wednesday

SECTION: Financial News

DISTRIBUTION: TO BUSINESS AND MEDICAL EDITORS

LENGTH: 1250 words

HEADLINE: Takeover of New Hampshire's Largest **Nursing Home Chain** by Genesis Health Ventures Seriously Undermines Patient Care;
Violations of Federal Patient Care Standards Increase 757% Under Genesis Ownership;
Second Report in Two Months Raises Questions About Quality of Care Provided by Nation's Fifth Largest **Nursing Home Chain**

DATELINE: WASHINGTON, Sept. 23

BODY:

The 1995 purchase of New Hampshire's McKerley Health Care Centers by Philadelphia-based Genesis Health Ventures resulted in a more than 750% increase in the number of **violations** of federal resident care standards, according to state inspection reports analyzed in a new study by the Service Employees International Union (SEIU).

The study, entitled "House of Cards: How Patient Care Was Undermined When Genesis Took Over New Hampshire's Largest **Nursing Home Chain**," shows that after the acquisition, Genesis facilities took in many more seriously ill residents who needed more hands-on care, cut overall staffing, and saw the number of patient care **violations** soar. The study is based on data collected by inspectors from the New Hampshire Department of Health and Human Services Division of Medical Services and on data from the annual reports filed by Genesis facilities for Medicaid reimbursement.

"President Clinton's initiative on nursing home abuse has drawn attention to the unacceptable treatment that the elderly have suffered in our nation's nursing homes," said Bonnie Ladin, SEIU's Nursing Home Director. "Our report raises serious questions about whether Genesis management is putting corporate profits before adequate staffing and quality care for New Hampshire nursing home residents."

In 1997, Genesis made a net profit of \$47.6 million. That year, 70 percent of the patient days of Genesis nursing homes in New Hampshire were paid by the state Medicaid program. Thus far, the New Hampshire Department of Health and Human Services has refused to fulfill their legal obligation to make available to the public the annual Medicaid cost reports Genesis files with the state. "A corporate strategy to reduce staffing levels represents a serious threat to nursing home residents," said Ladin. "New Hampshire taxpayers deserve to know what they are getting for their money and should demand to know how much profit Genesis is carrying back to Pennsylvania."



LEXIS·NEXIS[®]
A member of the Reed Elsevier plc group



LEXIS·NEXIS[®]
A member of the Reed Elsevier plc group



LEXIS·NEXIS[®]
A member of the Reed Elsevier plc group

PR Newswire, September 23, 1998

To publicize the report, SEIU is initiating a series of paid ads this week in New Hampshire and elsewhere including print, radio and billboards. Genesis residents, family members and the general public can call a toll-free number to receive a copy of the report and referrals to consumer and advocacy groups or to talk about their experiences with Genesis facilities (Copies of the report are also available by visiting the Web site, www.genesisreport.org).

The Report's Findings

The report reviewed New Hampshire state health inspections for the 10 long term care facilities acquired by Genesis from McKerley Health Care Centers in November 1995. Inspections for the years 1994 to 1998 were studied to examine conditions before and after the Genesis acquisition.

* After the acquisition, Genesis began taking in more seriously ill patients. Residents covered by Medicare require more nursing care due to their complex medical conditions. Recognizing this, Medicare reimburses nursing homes at a higher rate for these residents. From 1994 to 1997, the Medicare population in these ten Genesis homes increased from half of one percent to nearly ten percent.

* Despite an increase in the number of patients who needed more care, Genesis cut staffing levels. From 1995 to 1997, there was a 13 percent overall decrease in the hours per patient per day worked in the Genesis homes by Certified Nurse Aides, the staff responsible for providing 80 to 90 percent of the daily care to nursing home residents.

* Under Genesis management, citations for patient care violations by state health inspectors increased seven-fold. In 1994, the ten McKerley Health Care Centers' facilities were cited for seven patient care violations. In 1997, after the Genesis acquisition, these same facilities were cited a total of 60 times. Furthermore, since the Genesis acquisition, four of the ten facilities have been cited by the Department of Health for providing "substandard" care.

Recommendations for Consumers and State Officials

In light of the problems found with the quality of care in the ten Genesis facilities in New Hampshire, the report makes the following recommendations:

1. All states where Genesis operates should carefully review the patient care record of Genesis facilities there. All family members should closely monitor the care their relatives receive in Genesis facilities.
2. States should inspect and review Genesis facilities not as individual entities but as part of a single operation. Inspectors should look for problems and plans of correction covering the facilities as a group.
3. In order to ensure continuity and quality of care, states should adjust their reimbursement systems to punish operators who excessively fill nursing positions with temporary "agency" staff.
4. New Hampshire should make the annual cost reports filed by Genesis for Medicaid reimbursement available to the public.



LEXIS·NEXIS®
A member of the Reed Elsevier plc group



LEXIS·NEXIS®
A member of the Reed Elsevier plc group



LEXIS·NEXIS®
A member of the Reed Elsevier plc group

PR Newswire, September 23, 1998

Genesis has a history of inconsistent and unpredictable quality of care in a dozen other states where it owns or manages nursing homes, according to an earlier study by SEIU. "Rolling the Dice: Quality Failures at Genesis ElderCare," (July 1998) reviewed state health inspections for 140 Genesis facilities in twelve states for the period January 1994 to January 1998. Inspectors cited those facilities a total of 1,652 times for failure to meet minimum federal resident care requirements for nursing homes. Between August 1995 and January 1998, when government inspectors were required to rate the seriousness of these failures, fully one-third of all Genesis facilities reviewed were found to be "substandard" at some time.

On June 25, 1998, Pennsylvania health officials ordered the Genesis-run Cobbs Creek Nursing Center in Philadelphia closed and its residents transferred to other facilities after a ten month investigation found "a continuing inability on the part of Cobbs Creek not only to correct individual deficiencies, but to put systems in place to preclude the recurrence of additional serious **problems**," according to Joel H. Hersh, acting director of the Pennsylvania Department of Health's nursing home and hospital licensing bureau. In July 1998, the owner of Cobbs Creek, NewCourtland Inc., terminated Genesis' contract to manage seven additional facilities in the Philadelphia area.

Genesis Health Ventures, headquartered in Kennett Square, Pennsylvania, is the fifth largest **nursing home chain** in the United States with 319 homes in 16 states. Genesis **nursing homes** are operated under the brand name, Genesis ElderCare Network. Genesis is the dominant **nursing home chain** in several regional markets including: Boston, Western Massachusetts (Springfield and Worcester), Philadelphia, New Jersey, West Virginia and Baltimore.

SEIU is the largest union of health care workers in North America, with 600,000 health care members working in nursing homes, hospitals, HMOs, homecare agencies, and other facilities. SEIU represents more than 100,000 nursing home workers, making it the largest union of nursing home workers in North America. With a total of 1.3 million members in the United States, Canada and Puerto Rico, SEIU is the third largest and fastest growing union in the AFL-CIO.

SOURCE Service Employees International Union

CONTACT: Mark Smith, 603-491-4300, or Jill Gallagher, 202-898-3330, both for SEIU

LANGUAGE: ENGLISH

LOAD-DATE: September 24, 1998



LEXIS·NEXIS®

Ⓜ A member of the Reed Elsevier plc group



LEXIS·NEXIS®

Ⓜ A member of the Reed Elsevier plc group



LEXIS·NEXIS®

Ⓜ A member of the Reed Elsevier plc group

DATE: 3/18



**U.S. DEPARTMENT OF HEALTH AND HUMAN
SERVICES
ROOM 405H, HUMPHREY BUILDING
200 INDEPENDENCE AVE, SW
WASHINGTON, D.C. 20201**

PHONE: (202)690-7450

FAX: (202)690-8425

FROM:

☒ **JANE HORVATH**

☐ **HOLLY BODE**

☐ **SHARON CLARKIN**

☐ **BOB GUIDOS**

☐ **GREG JONES**

☐ **ANDREA LEVARIO**

☐ **ROGER MCCLUNG**

☐ **TANISHA PARKER**

☐ **JON RETZLAFF**

☐ **MARC SMOLONSKY**

☐ **STEPHANIE WILSON**

☐

TO: Chris Jennings

OFFICE: _____

ROOM: _____

PHONE: _____

FAX: 456 - 5542

Chris. any problem w/ this amend. to
Supplemental to find DAB NF backlog
w/ DOL unemploy training #? I've
sent to Dan M @ OMB also. Have
someone call me or Sharon Clarkin
@ 690 7450 Thank.

(INCLUDING COVER): 5

REMARKS: _____

OMB hasn't supported
no highlight

AMENDMENT TO BE OFFERED BY SENATOR GRASSLEY
TO S.544 MAKING SUPPLEMENTAL EMERGENCY APPROPRIATIONS
For the Purpose of Expediting Adjudication of Civil Monetary Penalties
By the Department of Health and Human Services Appeals Board

AMENDMENT

On page 29, insert after line 10:

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE SECRETARY
GENERAL DEPARTMENTAL MANAGEMENT**

For an additional amount for "general departmental management", \$1,400,000, to reduce the backlog of pending nursing home appeals before the Departmental Appeals Board.

On page 42, line 8, strike \$3,116,076,000 and insert \$3,114,676,000

On page 42, line 9, strike \$164,933,000 and insert \$163,533,000.

EXPLANATION AND JUSTIFICATION

This amendment provides an additional \$1,400,000 for the Department of Health and Human Services Appeals Board. The amendment would require that this sum be used by the Appeals Board to reduce a backlog of appeals by nursing facilities of civil monetary penalties levied by the Health Care Financing Administration for infractions of the Nursing Home Reform Act of 1987.

The Department of Health and Human Services Departmental Appeals Board hears and decides cases on appeal from program units of the Department. Lack of sufficient resources to handle a rapidly increasing case load has lead to a large backlog of pending cases. The major contributor to this backlog is a substantial increase in appeals of civil monetary penalties levied by HCFA on nursing facilities. Appeals of CMPs have increased at an accelerating rate each year since 1995. The rate of increase has accelerated further since January, 1999, reflecting the enhanced oversight and enforcement of nursing facilities undertaken by HCFA following a Presidential initiative and hearings by the Special Committee on Aging. The backlog of appeals subverts the purpose and effect of civil monetary penalties, delaying corrective action and improvements in the quality of care by nursing facilities. Delay in adjudication of appeals is also a burden to nursing facilities.

ADMINISTRATION BUDGET PROPOSAL FOR FY 2000

The Clinton Administration proposed an increase of \$2.8 million for FY 2000 for the Departmental Appeals Board. This amendment would speed up provision of those funds the Appeals Board could effectively use before the end of this fiscal year and thus permit the Appeals Board to begin immediately to take steps to reduce the backlog of appeals by nursing facilities.

DETAILS FOR HCFA NURSING HOME CASELOAD

<u>Year</u>	<u>Cases Received</u>	<u>Closed No Decision</u>	<u>Closed With Decision</u>	<u>Pending</u>
1996	335	101	22	212
1997	441	160	25	468
1998	483	303	22	626
1999 ¹	196	117	4	701

Note that, although the number of new cases received each year has increased, the number of cases decided has not, indicating lack of resources sufficient to keep up with the increasing annual number of new cases. Currently, the Appeals Board is receiving about 25 new cases per week. In earlier periods 8 to 10 new cases per week were being received.

¹As of January 22, 1999

1 DEPARTMENT OF AGRICULTURE

2 FOREST SERVICE

3 WILDLAND FIRE MANAGEMENT

4 Of the funds made available under this heading for
5 fire operations in previous Acts of Appropriation (exclusive
6 of amounts for hazardous fuels reduction), \$100,000,000
7 shall be transferred to the Knutson-Vandenberg fund es-
8 tablished pursuant to Section 3 of Public Law 71-319 (16
9 U.S.C. 576 et. seq.) within 10 days of passage of this Act.

10 CHAPTER 4

11 RELATED AGENCY

12 CORPORATION FOR PUBLIC BROADCASTING

13 For an additional amount for the Corporation for
14 Public Broadcasting, to remain available until expended,
15 \$18,000,000: *Provided*, That such funds be made available 15.7
16 to National Public Radio, as the designated manager of
17 the Public Radio Satellite System, for acquisition of sat-
18 ellite capacity.

19 CHAPTER 5

20 DEPARTMENT OF DEFENSE

21 MILITARY CONSTRUCTION, ARMY NATIONAL GUARD

22 For an additional amount for "Military Construction,
23 Army National Guard" to cover the incremental costs aris-
24 ing from the consequences of Hurricane Georges,

42

CHAPTER 6

DEPARTMENT OF LABOR

EMPLOYMENT AND TRAINING ADMINISTRATION

STATE UNEMPLOYMENT INSURANCE AND EMPLOYMENT

SERVICE OPERATIONS

Under this heading in section 101(f) of Public Law

105-277, delete "\$3,132,076,000" and insert

"\$3,116,076,000"; and delete "\$180,933,000" and insert

"\$164,933,000".

DEPARTMENT OF HEALTH AND HUMAN

SERVICES

ADMINISTRATION FOR CHILDREN AND FAMILIES

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES

(DEFERRAL)

Of the funds made available for grants to States for Temporary Assistance for Needy Families under section 403(a)(1) of the Social Security Act, \$350,000,000 shall not become available for obligation until October 1, 2001, in amounts bearing the same proportion to \$350,000,000 as such unobligated balance for such State bears to the sum of such unobligated balances for all States.

To: Devorah Adler
From: MT Connolly
Date: March 25, 1999
Re: Proposed Nursing Home Legislation: **DRAFT outline (not cleared for release by DOJ)** summarizing (1) enforcement measures currently available in abuse and neglect cases (2) HHS arguments opposing the proposed legislation, and (3) DOJ responses to the HHS arguments.

- I. **Proposed Nursing Home (NH) Legislation**: The Department of Justice (DOJ) has drafted legislation to address widespread abuse and neglect in nursing homes. The bill would provide criminal and civil remedies where a "pattern of violations" of provisions governing NHs result in "physical or mental harm." The primary goal of this bill is to fill gaps in current federal law including (1) no effective remedy to pursue NH chains and management companies; (2) no criminal authority; and (3) inadequate civil authority.
- II. **Current Remedies**: NH enforcement historically has been handled at the state and local level. Current remedies include:
- A. **State and local law enforcement authority**: State AGs, MFCUs and DAs usually pursue criminal cases against individual nursing home employees.
- Limit:
- States rarely pursue chains, management companies or officials.
 - Few states pursue civil cases and many have no authority to do so.
 - It is especially difficult for states to pursue cases against chains, management companies or corporate officers where HQ and/or offending facilities are located in another state or country.
- B. **HHS administrative authority**:
- Limit: HHS can take action only against a single facility, not against a chain or management company. We support HHS' request to expand its authority to reach chains (even if it overlaps with the authority we seek in this law).
1. **Suspension and termination of Medicare/Medicaid payments**:
- Limit:
- When termination leads to closures, some residents are exposed to serious health risks as a result of being moved.
 - Closures generate community opposition and negative press
2. **Civil money penalties (CMPs) up to \$10,000**:
- Limit:
- HHS' backlog in adjudicating CMP cases. See III(A)(3).
 - The Departmental Appeals Board often rules against HHS.
3. **Injunctive/regulatory remedies**: (e.g. receivership, temporary managers, re-surveying, barring admission of further federally-funded patients)
- Limit: These measures have not assured quality of care - facilities find loopholes, improving just long enough to pass the next survey.

C. *Federal law enforcement authority:*

Civil: The filing of False Claims Act qui tam cases alleging NH violations is on the rise. Given the dearth of damage theories for quality of care cases (without financial fraud), some USA Offices have settled for low damages but extensive injunctive relief ancillary to the FCA claims.

- Limit:**
- Using FCA cases to leverage injunctive relief already has elicited criticism that we are misusing the threat of FCA damages to obtain other relief and could again make the FCA vulnerable in Congress.
 - Establishing FCA quality of care liability poses serious challenges:
 - patient-by-patient malpractice-type proof (expert battles)
 - statistical analysis may not be used to prove FCA liability
 - difficult to prove violation of malleable HCFA regulations (e.g., "sufficient staffing," "inadequate hydration")
 - hard to prove that inadequate care as opposed to underlying condition of very sick patients caused the alleged harm
 - difficult to demonstrate HQ "knowledge" under FCA
 - Showing FCA damages — the monetary loss to US as a result of abuse and neglect or poor quality of care — is nearly impossible.

III. HHS Arguments Opposing Parts of the Proposed Nursing Home Legislation.

A. *Civil penalty provision — HHS opposes this section arguing that:*

1. **This CMP authority will duplicate and interfere with HHS' CMPs and HHS has sought funding to improve its CMP efforts.**

DOJ response:

- HHS' Departmental Appeals Board (DAB) has a 600+ case/18 month back log on adjudicating CMP cases, rendering CMPs a relatively ineffective remedy.
- The DAB is an unpredictable forum. It often rules against HHS; we may fare better before local federal judges.
- HHS' CMP authority has not improved quality of care in NHs.
- Giving DOJ civil penalty authority takes nothing away from HHS.

2. **CMPs are regulatory remedies properly HHS' domain.**

DOJ response:

- HHS has no CMP authority to pursue chains, management companies or corporate officers — a huge enforcement gap.
- CMPs are quintessentially a law enforcement tool, although they also may be available to an agency to achieve a regulatory goal. (See two MOUs between DOJ and HHS demonstrating that

historically, enforcement measures like CMPs are properly the province of DOJ.

- As the name suggests, CMPs are more in the nature of a penalty, than a regulatory sanction (and often are subject to DOJ terms).
- DOJ and agencies can have overlapping penalty authority (e.g. FCA/PFCRA) or DOJ alone may possess that authority.

3. **HHS sought \$60 million in the NH arena, most of it for "enforcement."**

DOJ response:

- We fully support (and encourage) additional regulation of nursing homes so that there are more definite standards of participation, including demonstrated financial ability to provide quality of care.
- DOJ shouldering some of the enforcement burden could free up HHS resources for other regulatory efforts -- a positive step.

4. **This section applies to single facilities, not only chains as HHS previously understood was DOJ's goal in this legislation.**

DOJ response:

Occasionally, for tactical, resource or other reasons, DOJ might pursue a case that HHS could or would not. It would undermine the collective federal enforcement effort to preclude DOJ from pursuing a single facility with egregious violations causing harm.

5. **HHS believed that DOJ would seek authority to pursue only "egregious" cases, but this Act covers even "minor" violations.**

DOJ response:

- By its terms, only a pattern of violations (not a single instance) resulting in harm, is actionable under this legislation.
- The "pattern" and "harm" requirements are significant limitations on federal authority, raising the bar on all actions under this Act.
- (Almost) by definition, repeated or widespread violations that result in harm are egregious.
- HHS has proposed no alternative language to limit the Act's scope to egregious cases. We avoided the terms "abuse" and "neglect" believing that HCFA would oppose their use because it has not yet defined them (formally) itself.
- We tried to achieve a balance between keeping the bar high while not making cases brought under this Act impossible to prove.
- We are open to discussing any alternative language HHS suggests. It has not done so despite having had the proposal since 1/29/99.

6. **The high penalties will result in NH closures to which communities and advocacy groups are adamantly opposed.**

- As in FCA cases, we will take a defendant's ability to pay into consideration in deciding how to proceed.
- When a defendant argues that it lacks the ability to pay the amount sought under the FCA, we seek confirmatory financial information and structure any deal based on what the defendant can pay without bankrupting it.
- One of the OVC focus group's strongest recommendations was improved law enforcement and DOJ involvement.

7. **The act should condition DOJ's pursuit of CMP actions on a referral by HHS. (USAO acted over HCFA's objection in Greenbelt)**

DOJ response

- Congress conditioned HHS's CMP actions on DOJ procedures and concurrence.
- There is no precedent for conditioning a DOJ CMP action on an agency referral. (Indeed, DOJ can take much more extreme action without agency concurrence, such as take over labor unions.)
- CMPs are inherently a law enforcement tool and properly the province of DOJ; thus referrals in this area would be inappropriate.

Compromise proposed by DOJ:

- We offered to enter into an MOU requiring DOJ to consult with HHS before bringing a CMP action under this section. (Civil cases where agency and DOJ positions conflict in any event must be elevated to the Assistant Attorney General or above.)
- DOJ alerts HHS of quality of care allegations made in FCA qui tam cases by sending "call letters" to HHS/OGC and HHS/OIG.
- Before filing, declining or settling any case, including a quality of care case, we always seek the agency's views.
- When DOJ learned about serious financial and quality of care concerns relating to Vencor, it notified HHS at once.
- In Greenbelt, Main Justice sided with HHS against the USAO.
- For every Greenbelt, there are many more cases with good results.

A. **Other appropriate remedies (referred to as the "injunctive provision"):**

HHS opposes the section as currently drafted because:

1. **HHS seeks a statutory term conditioning DOJ action on an HHS referral because relief under this section is regulatory in nature and a MOU term will not suffice because HHS fears that DOJ will violate it.**

DOJ response:

- Not all actions under this section would be "regulatory" — DOJ could seek equitable disgorgement of illegal profits under this section.

- DOJ has had sole authority to pursue and has pursued injunctive CRIPA actions (the type HHS fears) for 19+ years without complaint from or dispute with HHS.
- Relief under CRIPA requires no harm or pattern, but only the "violation of a federal right" (although the AG must sign CRIPA complaints and the US Attorneys offices cannot bring them).

Compromise proposed by DOJ:

- We acknowledged that actions under this section could (but would not necessarily) overlap with HHS' regulatory authority.
- We offered to shop within DOJ an MOU term requiring HHS concurrence before DOJ pursues action under this section.
- DOJ opposes including the concurrence provision in the statute because it might result in defendants seeking discovery on that issue or asserting rights based on that requirement.

IV. DOJ Steps Responsive to HHS concerns

- A. DOJ agreed to enter into an MOU under which it would agree to consult with HHS in CMP cases (as it already does as a matter of practice).
- B. DOJ agreed to a MOU term under which HHS would be required to concur to DOJ's action, even where DOJ alone identified the case.
- C. DOJ will support HCFA efforts to obtain administrative authority to address quality of care problems involving chains and management companies (even though it would overlap with the authority sought in this proposal).
- D. DOJ will continue to work with HHS toward acceptable definitions of "harm" and "pattern" (versus a numerical threshold) and "widespread" that are not at odds with HHS regulatory definitions.
- E. We will add (subject to clearance by the components) adding HHS' provision that nothing in the Act may be construed to deprive HHS of authority under the SSA.
- F. DOJ doesn't oppose moving the NH provisions out of the fraud section of the Crime.

CIVIL DIVISION
COMMERCIAL LITIGATION BRANCH
FRAUD SECTION



FROM: U.S. Department of Justice
Civil Division
Commercial Litigation Branch
Fraud Section

U.S. Department of Justice
P.O. Box 261
Ben Franklin Station
Washington, D.C. 20044

Street Address:
Patrick Henry Building
601 D Street, N.W.
Washington, D.C. 20004

Fax No. (202) 616-3085
Voice No.

SENT BY: MT Conno 16

TO: Devorah Adler

FAX No. 456-5557

NUMBER OF PAGES SENT (INCLUDING COVER PAGE):

SPECIAL INSTRUCTIONS: QS promised. as soon as I get your email, I'll

IMPORTANT: This facsimile is intended only for the use of the individual or entity to which it is addressed. It may contain information that is privileged, confidential, or otherwise protected from disclosure under applicable law. If the reader of this transmission is not the intended recipient or the employee or agent responsible for delivering the transmission to the intended recipient, you are hereby notified that any dissemination, distribution, copying or use of this transmission or its contents is strictly prohibited. If you have received this transmission in error, please notify us by telephoning and return the original transmission to us at the above address.

email it
too.

MS

MEMORANDUM OF UNDERSTANDING BETWEEN THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
AND THE DEPARTMENT OF JUSTICE
REGARDING IMPLEMENTATION OF
SECTION 1128A OF THE SOCIAL SECURITY ACT

I. DEFINITIONS

For purposes of this memorandum:

1. "Attorney General" means the Attorney General of the United States, or his designee;
2. "Secretary" means the Secretary of the Department of Health and Human Services, or his designee;
3. "Department of Justice" means the United States Department of Justice or an Office of a United States Attorney;
4. "United States Attorney" means the United States Attorney who has jurisdiction of a case;
5. "Civil Division" means the Assistant Attorney General of the Civil Division of the Department of Justice, or any of his subordinates authorized to consider referrals under this memorandum;
6. "Criminal Division" means the Assistant Attorney General of the Criminal Division of the Department of Justice, or any of his subordinates authorized to consider referrals under this memorandum;
7. "administrative proceeding" means the procedure specified in section 1128A of the Social Security Act, and regulations promulgated thereunder, whereby the Secretary may assess a monetary penalty for the filing of a false claim;
8. "total assessment" means the total potential amount of a penalty which may be levied against a person in an administrative proceeding, including the amount of any fines and any amount permitted by law in lieu of damages; and
9. "the delegated authority of the United States Attorney" means the amount specified by the Attorney General, below which the merits of a case may be considered by the appropriate United States Attorney.

II. AUTHORIZATION PROCEDURES

A. IN GENERAL

The Secretary may not commence an administrative proceeding in any case until he has notified the Department of Justice of his intent, he has referred the case to the Department

-2-

of Justice, and the Department of Justice has had an opportunity to consider the merits of the case, in accordance with procedures set forth herein.

B. CASES IN WHICH THE TOTAL ASSESSMENT WOULD BE WITHIN THE DELEGATED AUTHORITY OF THE UNITED STATES ATTORNEY

The Secretary may not commence an administrative proceeding until the case has been referred to the United States Attorney and:

1. The United States Attorney declines both civil and criminal prosecution; or
2. The United States Attorney authorizes the Secretary to do so.

C. CASES IN WHICH THE TOTAL ASSESSMENT WOULD EXCEED THE DELEGATED AUTHORITY OF THE UNITED STATES ATTORNEY

The Secretary may not commence an administrative proceeding until:

- I. (a) The case has been referred to the United States Attorney for criminal prosecution and (i) prosecution has been declined, or (ii) if prosecution has been accepted, all criminal processes have been completed; and
- (b) (i) The case has been referred to the Civil Division for civil action, and civil action has been declined, or (ii) the Civil Division has been notified of the Secretary's intention to begin administrative proceedings, and the time period specified in section III.A. has expired;

or

- I. The case has been referred under the two preceding paragraphs and both the United States Attorney and the Civil Division authorize the Secretary to commence an administrative proceeding.

III. MISCELLANEOUS PROVISIONS

A. TIME PERIOD FOR CONSIDERATION

The Civil Division will respond to notices of intention to commence administrative proceedings within 60 days of the date of receipt of a case under section II.C.1. (b) (ii). The Civil Division will send an acknowledgment to the

-1-

ary at the time each case is received. In any case criminal prosecution has been declined, or regarding criminal processing is complete, the Department may proceed administratively proceeding if: (1) the Secretary gives the Civil Division a second notice of his intent to proceed administratively 20 days in advance of the expiration of the 60 day period; and (2) the Civil Division agrees to notify the Secretary within the 60 day period of his intent to proceed with civil litigation.

RECONSIDERATION

1. The Secretary shall have a continuing duty to revise and supplement the information furnished in a case referred pursuant to sections II.B. and II.C., upon discovery of any new information material to the case. The following information shall be deemed material: the addition of another person or persons as potential respondent(s) in the anticipated administrative proceeding; or the possibility of bribery, gratuities, conflict of interest, or other corruption or similar activity on the part of any officer, employee, or agent of the United States or any State.
2. Upon submission to the Secretary of a written determination by the Attorney General that the continuation of an administrative proceeding may adversely affect any pending or potential criminal judicial proceeding relating thereto, such administrative proceeding shall be immediately stayed and may be recommenced only upon written authorization of the Attorney General.

C. EXPEDITED CONSIDERATION

If it appears to the Secretary that any circumstance compels expedited consideration of a referral, he may request authorization orally. Upon oral authorization by the Attorney General, the Secretary may immediately commence an administrative proceeding; in such instances, the Secretary shall provide relevant information pertaining to the case in writing to the Department of Justice within 10 days of the oral authorization.

D. CONTENT OF REFERRAL TO THE DEPARTMENT OF JUSTICE

The referral to the United States Attorney and the Civil Division (or, where applicable, to the Criminal Division) should be in writing and include the following information: name of all potential defendants including

-4-

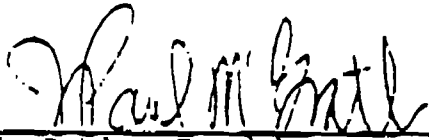
business entities, amount of potential monetary loss, identity of Federal program or operation involved, description of fraudulent activity, identity and status of any pending criminal or civil investigation or litigation involving the same or related persons or entities, outline of any evidence or suspicion of corruption of a public official, date of claim, and any other data which would affect the Department of Justice decision to proceed criminally or civilly in district court.

E. REFERRALS TO THE CRIMINAL DIVISION

Nothing in this memorandum shall prevent the Secretary from referring a case for consideration of criminal prosecution to the Criminal Division rather than to the United States Attorney. Where a case is referred under this paragraph to the Criminal Division, the Criminal Division shall carry out the responsibilities of the United States Attorney, regarding consideration of criminal prosecution, which are described in paragraph B or paragraph C of section II.

F. REVIEW OF MEMORANDUM

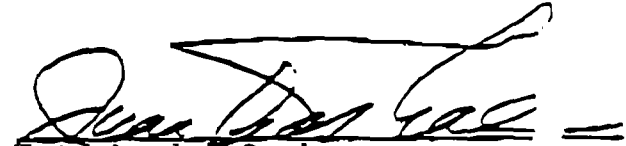
The General Counsel and Inspector General of the Department of Health and Human Services will meet once a year with the Assistant Attorneys General of the Civil and Criminal Divisions to evaluate the effectiveness of the operations of the memorandum and any need for modifications.



J. Paul McGrath
Assistant Attorney General
Civil Division

2/2/93

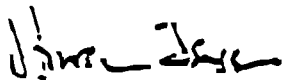
Date



Juan A. del Real
General Counsel

JAN 26 1993

Date



D. Lowell Jensen
Assistant Attorney General
Criminal Division

February 15, 1993

Date



Richard P. Kusserow
Inspector General

JAN 24 1993

Date

JAN-25-96 THU 14:04

**MEMORANDUM OF UNDERSTANDING
BETWEEN THE U.S. DEPARTMENT OF JUSTICE
AND THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**

I. PURPOSE

This Memorandum of Understanding ("MOU") between the undersigned parties representing the U.S. Department of Justice ("DOJ") and the U.S. Department of Health and Human Services ("HHS") constitutes an agreement as to the terms and conditions necessary to implement § 1128A(c)(1) of the Social Security Act ("the Act"), 42 U.S.C. § 1320a-7a(c)(1). This section requires the imposition of civil money penalties ("CMP") only as authorized by the Attorney General pursuant to procedures agreed upon by the Attorney General and the Secretary. This MOU governs only the imposition of CMPs by HHS that may be assessed against skilled nursing facilities and nursing facilities as authorized by §§ 1819(h)(2)(B) and 1819(h)(3) of the Act, 42 U.S.C. §§ 1395i-3(h)(2)(B) and 1396r(h)(3). CMPs under these provisions became available to the Secretary on July 1, 1995 pursuant to rules that became effective on that date.

II. Objectives

A. It is the objective of the DOJ to be able to preserve its interest in pursuing investigations of fraud and abuse that may occur in nursing homes without facing potential interference that might be caused by a parallel administrative proceeding.

B. It is the objective of HHS, and the Health Care Financing Administration ("HCFA"), to be able to move swiftly, through the imposition of CMPs and other remedies, to protect the health and safety of residents residing in nursing homes that participate in the Medicare and Medicaid programs when nursing home providers violate requirements at §§ 1819 and 1819 of the Act, 42 U.S.C. §§ 1395i-3 and 1396r.

III. Procedures

A. Acting as HCFA's agent, states conduct surveys of nursing homes to determine if they comply with Federal requirements for participation in the Medicare program. Where a State survey agency identifies noncompliance in facilities that participate in the Medicare program, or both the Medicare and Medicaid programs, the State survey agency may recommend to HCFA that certain remedies be imposed, including CMPs. For such facilities, only HCFA, through its Regional Offices, may impose CMPs. The contact person for such actions is the Associate Regional Administrator for Health Standards and Quality in the appropriate HCFA Regional office or the person indicated on the notification by HCFA to the United States Attorney ("USAO") of the specific CMP action. Within thirty (30) days of the signing of this MOU, HCFA will furnish to DOJ a list identifying each Associate Regional Administrator having the authority to impose CMPs on nursing

JAN-25-96 THU 14:05

homes. Within thirty (30) days of the signing of this MOU, DOJ will provide to HCFA the names of the appropriate persons in the USAO to whom notification shall be made of HCFA CMP actions.

B. Poor performing facility CMP cases. In those cases where HCFA seeks to impose a CMP on a poor performing facility, HCFA will send a notice to the noncompliant facility advising it that a CMP is being imposed. The definition of "poor performing facility" appears in HCFA's State Operations Manual, and has been furnished to DOJ. Should HCFA revise the definition at any time, HCFA shall promptly advise DOJ of that fact and furnish to the USAOs a copy of the revised definition. Simultaneous with HCFA's notification to a facility that it is imposing a CMP, HCFA will provide to the USAO, or its designated representative, for the District in which the facility is located, by hard copy and/or electronic transmission, a copy of the notice it has sent to the facility along with a copy of the Statement of Deficiencies (Form 2567) upon which the CMP is based. The USAO will have fourteen (14) days from receipt of this information to advise HCFA that it ought not proceed further with the CMP, and in no case may HCFA seek to collect, or accept payment of, the CMP before the USAO has had its fourteen (14) day opportunity to review the matter. Should the USAO advise HCFA not to proceed with the CMP in a manner consistent with the procedures set forth in section IV of this MOU, HCFA will rescind the CMP.

C. Immediate jeopardy cases. In those cases of immediate jeopardy (as defined in 59 Fed. Reg. 56238 (1994) [to be codified at 42 C.F.R. § 488.301]), where HCFA seeks to impose a CMP, HCFA will send a notice to the noncompliant facility advising it that a CMP is being imposed. Simultaneous with HCFA's notification to a facility that it is imposing a CMP, HCFA will provide to the USAO, or its designated representative, for the District in which the facility is located, by hard copy and/or electronic transmission, a copy of the notice it has sent to the facility along with a copy of the Statement of Deficiencies (Form 2567) upon which the CMP is based. The USAO will have fourteen (14) days from receipt of this information to advise HCFA that it ought not proceed further with the CMP, and in no case may HCFA seek to collect, or accept payment of, the CMP before the USAO has had its fourteen (14) day opportunity to review the matter. Should the USAO advise HCFA not to proceed with the CMP in a manner consistent with the procedures set forth in section IV of this MOU, HCFA will rescind the CMP.

D. All other cases. In all other cases of facility noncompliance, when HCFA seeks to impose a CMP it will advise the facility of the possibility that this remedy may be imposed. Simultaneous with the time that HCFA sends such a notice to the facility, but in no case less than fourteen (14) days before the imposition of a CMP, HCFA shall send a copy of the notice, by hard copy and/or electronic transmission, to the USAO, or its designated representative, for the District in which the facility is located. Along with a copy of the notice HCFA will also

responsible for assuring that the USAO receives a copy of the Statement of Deficiencies (Form 2567) upon which the CMP would be based. In no case under this subsection may HCFA seek to impose, collect, or accept payment of, a CMP before the USAO has had its fourteen (14) day opportunity to review the matter. Unless the USAO advises HCFA within fourteen (14) days of its receipt of the notice that the CMP should not be imposed, HCFA may assess the CMP as indicated in the notice to the facility. If the USAO concludes its review in less than fourteen (14) days, and advises HCFA that it may proceed with the CMP, HCFA will be free to impose, collect, and accept payment of the CMP at that time. Should the USAO advise HCFA not to proceed with the CMP in a manner consistent with the procedures set forth in section IV of this MOU, HCFA shall not impose, collect or accept payment of the CMP.

E. In all notifications by HCFA to the USAO of CMPs proposed or imposed pursuant to paragraphs III B., C., and D. of this MOU, HCFA will provide to the USAO, to the extent that it is readily available to HCFA, the following information:

1. the number of residents affected by the deficiency;
2. an estimate of how long the deficiency has existed;
3. the identity of the owners and managers of the facility in question;
4. the names and addresses of other facilities owned or managed by the same individuals or entities; and
5. an estimate of the actual damage which was caused by the deficiency (i.e. injury, death, additional medication or treatment).

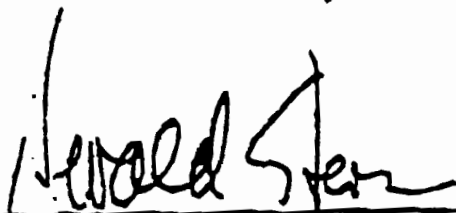
F. Consistent with law enforcement needs and limitations on permissible disclosure of such information, the USAO shall advise HCFA of any investigations it is pursuing against a nursing provider certified for participation under the Medicare or Medicaid programs where the USAO has information that might have a bearing on the health and safety of residents in those facilities in order to enable HCFA to undertake its statutory obligations to protect those residents' interests.

G. The procedures set forth herein shall be reviewed by HCFA and DOJ within one year of the date of this MOU to evaluate its effectiveness and any need for modification.

IV. Intent of the Parties

It is the parties' intent that the procedures set forth above by which the USAO may cause HCFA not to proceed with a CMP, will be used where the USAO has a good faith basis to request that a CMP not be pursued. Where the USAO has no ongoing investigation, but intends to initiate one only after receiving notice of HCFA's imposition of (or intent to impose) a CMP, the USAO and HCFA

shall discuss possible ways to allow HCFA to proceed with the CMP in a manner that accommodates the interests of both HCFA and the USAO. Where the USAO believes that a CMP imposed by HCFA may interfere with an ongoing investigation of that facility, the USAO shall make every effort, consistent with law enforcement needs and limitations on permissible disclosure of such information, to contact HCFA to determine if the CMP may proceed.



Gerald Stern
Special Counsel for Health Care Fraud
U.S. Department of Justice

Date:



Bruce C. Vladeck, Administrator
Health Care Financing Administration
U.S. Department of Health and Human
Services

Date: AUG 31 1995

Associate Regional Administrators--Division of Health Standards and Quality

Region I

Inda Silva
Associate Regional Administrator
Division of Health Standards and Quality
Health Care Financing Administration
JFK Federal Building Room 2275
Boston Massachusetts 02203-0003
Telephone: (617) 565-1322
Doris West, MRS 565-1320
PROF ID HCFABOS GA-69

Region II

Alan J. Saperstein
Associate Regional Administrator
Division of Health Standards and Quality
Health Care Financing Administration
26 Federal Plaza Room 3821
New York, New York 10278-0063
Telephone: (212) 264-1121
Gail Weinreb, MRS 264-4680
PROF ID HCFANYC GB-23

Region III

Claudette V. Campbell
Associate Regional Administrator
Division of Health Standards and Quality
Health Care Financing Administration
P.O. Box 7760
Philadelphia, Pennsylvania 19101-7760
Telephone: (215) 596-6571
FAX 596-3084
Therine McCoy, MRS 596-1856
PROF ID HCFAPHI GC-86

Region IV

William R. Lyons
Associate Regional Administrator
Division of Health Standards and Quality
Health Care Financing Administration
101 Marietta Tower Suite 601
Atlanta, Georgia 30323-2711
Telephone: (404) 331-2361
FAX 880-2729
Clyde Thomas, MRS (404) 730-3782
PROF ID HCFATL CO-23

Region V

Walter V. Kummer
Associate Regional Administrator
Division of Health Standards and Quality
Health Care Financing Administration
15th Floor
105 West Adams Street
Chicago, Illinois 60603-6201
Telephone: (312) 353-9804
Sina Mercado, MRS 353-3642
PROF ID HCFACHI GR09

Region VI

NCF-2
Roger Perez
Associate Regional Administrator
Division of Health Standards and Quality
HHS Health Care Financing Administration
1200 Main Street, Suite 1940
Dallas, Texas 75202-4348
Telephone: (214) 767-6305 FAX 729-0
R. David Simpton, MRS 767-0345
PROF ID HCFADAL GV-26

Region VII

Tom Lent
Acting Associate Regional Administrator
Division of Health Standards and Quality
Health Care Financing Administration
New Federal Office Building
601 East 12th Street Room 242
Kansas City, Missouri 64106-2808
Telephone: (816) 426-2408
Greg Lear, MRS 426-5746
PROF ID HCFKAN GO-62

Region VIII

Spencer K. Ericson
Associate Regional Administrator
Division of Health Standards and Quality
Health Care Financing Administration
Federal Office Building, Room 1185
1961 Stout Street
Denver, Colorado 80294-3538
Telephone: (303) 844-4721
Jean Nofles, MRS 844-4721
PROF ID HCFADEN GH-14

Region IX

Nancy Rothwell
Acting Associate Regional Administrator
Division of Health Standards and Quality
Health Care Financing Administration
75 Hawthorne Street 4th Floor
San Francisco, California 94105-3903
Telephone: (415) 744-3679
Lankford Williams, MRS 744-3720
PROF ID HCFASFO GM-12

Region X

Steven D. Helgersen, M.D., M.P.H.
Associate Regional Administrator
Division of Health Standards and Quality
Health Care Financing Administration
Blanchard Plaza Building
2201 Sixth Avenue, Mail Stop BX-42
Seattle, Washington 98121-2500
Telephone: (206) 615-2310
Bunnee A. Butterfield, MRS 615-2317
PROF ID HCFASIA GJ-56

Change made to Region IX: Nancy Rothwell is now the Acting Associate Regional Administrator.
NOTE: In compliance with postal regulations, labels and envelopes addressed for the Dallas Regional office should be prepared exactly as the sample shown below:

NCF-2
MR ROGER PEREZ
ASSOCIATE REGIONAL ADMINISTRATOR
DIVISION OF HEALTH STANDARDS AND QUALITY

To: Devorah Adler
From: MT Connolly
Date: March 25, 1999
Re: Proposed Nursing Home Legislation: **DRAFT** outline (not cleared for release by DOJ) summarizing (1) enforcement measures currently available in abuse and neglect cases (2) HHS arguments opposing the proposed legislation, and (3) DOJ responses to the HHS arguments.

I. **Proposed Nursing Home (NH) Legislation**: The Department of Justice (DOJ) has drafted legislation to address widespread abuse and neglect in nursing homes. The bill would provide criminal and civil remedies where a "pattern of violations" of provisions governing NHs result in "physical or mental harm." The primary goal of this bill is to fill gaps in current federal law including (1) no effective remedy to pursue NH chains and management companies; (2) no criminal authority; and (3) inadequate civil authority.

II. **Current Remedies**: NH enforcement historically has been handled at the state and local level. Current remedies include:

A. ***State and local law enforcement authority***: State AGs, MFCUs and DAs usually pursue criminal cases against individual nursing home employees.

Limit: • States rarely pursue chains, management companies or officials.
• Few states pursue civil cases and many have no authority to do so.
• It is especially difficult for states to pursue cases against chains, management companies or corporate officers where HQ and/or offending facilities are located in another state or country.

B. ***HHS administrative authority***:

Limit: HHS can take action only against a single facility, not against a chain or management company. We support HHS' request to expand its authority to reach chains (even if it overlaps with the authority we seek in this law).

1. **Suspension and termination of Medicare/Medicaid payments**:

Limit: • When termination leads to closures, some residents are exposed to serious health risks as a result of being moved.
• Closures generate community opposition and negative press

2. **Civil money penalties (CMPs) up to \$10,000**:

Limit: • HHS' backlog in adjudicating CMP cases. See III(A)(3).
• The Departmental Appeals Board often rules against HHS.

3. **Injunctive/regulatory remedies**: (e.g. receivership, temporary managers, re-surveying, barring admission of further federally-funded patients)

Limit: These measures have not assured quality of care - facilities find loopholes, improving just long enough to pass the next survey.

C. Federal law enforcement authority:

Civil: The filing of False Claims Act qui tam cases alleging NH violations is on the rise. Given the dearth of damage theories for quality of care cases (without financial fraud), some USA Offices have settled for low damages but extensive injunctive relief ancillary to the FCA claims.

- Limit:
- Using FCA cases to leverage injunctive relief already has elicited criticism that we are misusing the threat of FCA damages to obtain other relief and could again make the FCA vulnerable in Congress.
 - Establishing FCA quality of care liability poses serious challenges:
 - patient-by-patient malpractice-type proof (expert battles)
 - statistical analysis may not be used to prove FCA liability
 - difficult to prove violation of malleable HCFA regulations (e.g., "sufficient staffing," "inadequate hydration")
 - hard to prove that inadequate care as opposed to underlying condition of very sick patients caused the alleged harm
 - difficult to demonstrate HQ "knowledge" under FCA
 - Showing FCA damages — the monetary loss to US as a result of abuse and neglect or poor quality of care — is nearly impossible.

III. HHS Arguments Opposing Parts of the Proposed Nursing Home Legislation.

A. Civil penalty provision — HHS opposes this section arguing that:

1. **This CMP authority will duplicate and interfere with HHS' CMPs and HHS has sought funding to improve its CMP efforts.**

DOJ response:

- HHS' Departmental Appeals Board (DAB) has a 600+ case/18 month back log on adjudicating CMP cases, rendering CMPs a relatively ineffective remedy.
- The DAB is an unpredictable forum. It often rules against HHS; we may fare better before local federal judges.
- HHS' CMP authority has not improved quality of care in NHs.
- Giving DOJ civil penalty authority takes nothing away from HHS.

2. **CMPs are regulatory remedies properly HHS' domain.**

DOJ response:

- HHS has no CMP authority to pursue chains, management companies or corporate officers — a huge enforcement gap.
- CMPs are quintessentially a law enforcement tool, although they also may be available to an agency to achieve a regulatory goal. (See two MOUs between DOJ and HHS demonstrating that

historically, enforcement measures like CMPs are properly the province of DOJ.

- As the name suggests, CMPs are more in the nature of a penalty, than a regulatory sanction (and often are subject to DOJ terms).
- DOJ and agencies can have overlapping penalty authority (e.g. FCA/PFCRA) or DOJ alone may possess that authority.

3. **HHS sought \$60 million in the NH arena, most of it for "enforcement."**

DOJ response:

- We fully support (and encourage) additional regulation of nursing homes so that there are more definite standards of participation, including demonstrated financial ability to provide quality of care.
- DOJ shouldering some of the enforcement burden could free up HHS resources for other regulatory efforts -- a positive step.

4. **This section applies to single facilities, not only chains as HHS previously understood was DOJ's goal in this legislation.**

DOJ response:

Occasionally, for tactical, resource or other reasons, DOJ might pursue a case that HHS could or would not. It would undermine the collective federal enforcement effort to preclude DOJ from pursuing a single facility with egregious violations causing harm.

5. **HHS believed that DOJ would seek authority to pursue only "egregious" cases, but this Act covers even "minor" violations.**

DOJ response:

- By its terms, only a pattern of violations (not a single instance) resulting in harm, is actionable under this legislation.
- The "pattern" and "harm" requirements are significant limitations on federal authority, raising the bar on all actions under this Act.
- (Almost) by definition, repeated or widespread violations that result in harm are egregious.
- HHS has proposed no alternative language to limit the Act's scope to egregious cases. We avoided the terms "abuse" and "neglect" believing that HCFA would oppose their use because it has not yet defined them (formally) itself.
- We tried to achieve a balance between keeping the bar high while not making cases brought under this Act impossible to prove.
- We are open to discussing any alternative language HHS suggests. It has not done so despite having had the proposal since 1/29/99.

6. **The high penalties will result in NH closures to which communities and advocacy groups are adamantly opposed.**

- As in FCA cases, we will take a defendant's ability to pay into consideration in deciding how to proceed.
- When a defendant argues that it lacks the ability to pay the amount sought under the FCA, we seek confirmatory financial information and structure any deal based on what the defendant can pay without bankrupting it.
- One of the OVC focus group's strongest recommendations was improved law enforcement and DOJ involvement.

7. **The act should condition DOJ's pursuit of CMP actions on a referral by HHS. (USAO acted over HCFA's objection in Greenbelt)**

DOJ response

- Congress conditioned HHS's CMP actions on DOJ procedures and concurrence.
- There is no precedent for conditioning a DOJ CMP action on an agency referral. (Indeed, DOJ can take much more extreme action without agency concurrence, such as take over labor unions.)
- CMPs are inherently a law enforcement tool and properly the province of DOJ; thus referrals in this area would be inappropriate.

Compromise proposed by DOJ:

- We offered to enter into an MOU requiring DOJ to consult with HHS before bringing a CMP action under this section. (Civil cases where agency and DOJ positions conflict in any event must be elevated to the Assistant Attorney General or above.)
- DOJ alerts HHS of quality of care allegations made in FCA qui tam cases by sending "call letters" to HHS/OGC and HHS/OIG.
- Before filing, declining or settling any case, including a quality of care case, we always seek the agency's views.
- When DOJ learned about serious financial and quality of care concerns relating to Vencor, it notified HHS at once.
- In Greenbelt, Main Justice sided with HHS against the USAO.
- For every Greenbelt, there are many more cases with good results.

A. **Other appropriate remedies (referred to as the "injunctive provision"):**

HHS opposes the section as currently drafted because:

1. **HHS seeks a statutory term conditioning DOJ action on an HHS referral because relief under this section is regulatory in nature and a MOU term will not suffice because HHS fears that DOJ will violate it.**

DOJ response:

- Not all actions under this section would be "regulatory" — DOJ could seek equitable disgorgement of illegal profits under this section.

- DOJ has had sole authority to pursue and has pursued injunctive CRIPA actions (the type HHS fears) for 19+ years without complaint from or dispute with HHS.
- Relief under CRIPA requires no harm or pattern, but only the "violation of a federal right" (although the AG must sign CRIPA complaints and the US Attorneys offices cannot bring them).

Compromise proposed by DOJ:

- We acknowledged that actions under this section could (but would not necessarily) overlap with HHS' regulatory authority.
- We offered to shop within DOJ an MOU term requiring HHS concurrence before DOJ pursues action under this section.
- DOJ opposes including the concurrence provision in the statute because it might result in defendants seeking discovery on that issue or asserting rights based on that requirement.

IV. DOJ Steps Responsive to HHS concerns

- A. DOJ agreed to enter into an MOU under which it would agree to consult with HHS in CMP cases (as it already does as a matter of practice).
- B. DOJ agreed to a MOU term under which HHS would be required to concur to DOJ's action, even where DOJ alone identified the case.
- C. DOJ will support HCFA efforts to obtain administrative authority to address quality of care problems involving chains and management companies (even though it would overlap with the authority sought in this proposal).
- D. DOJ will continue to work with HHS toward acceptable definitions of "harm" and "pattern" (versus a numerical threshold) and "widespread" that are not at odds with HHS regulatory definitions.
- E. We will add (subject to clearance by the components) adding HHS' provision that nothing in the Act may be construed to deprive HHS of authority under the SSA.
- F. DOJ doesn't oppose moving the NH provisions out of the fraud section of the Crime.

MEMORANDUM OF UNDERSTANDING BETWEEN THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
AND THE DEPARTMENT OF JUSTICE
REGARDING IMPLEMENTATION OF
SECTION 1128A OF THE SOCIAL SECURITY ACT

I. DEFINITIONS

For purposes of this memorandum:

1. "Attorney General" means the Attorney General of the United States, or his designee;
2. "Secretary" means the Secretary of the Department of Health and Human Services, or his designee;
3. "Department of Justice" means the United States Department of Justice or an Office of a United States Attorney;
4. "United States Attorney" means the United States Attorney who has jurisdiction of a case;
5. "Civil Division" means the Assistant Attorney General of the Civil Division of the Department of Justice, or any of his subordinates authorized to consider referrals under this memorandum;
6. "Criminal Division" means the Assistant Attorney General of the Criminal Division of the Department of Justice, or any of his subordinates authorized to consider referrals under this memorandum;
7. "administrative proceeding" means the procedure specified in section 1128A of the Social Security Act, and regulations promulgated thereunder, whereby the Secretary may assess a monetary penalty for the filing of a false claim;
8. "total assessment" means the total potential amount of a penalty which may be levied against a person in an administrative proceeding, including the amount of any fines and any amount permitted by law in lieu of damages; and
9. "the delegated authority of the United States Attorney" means the amount specified by the Attorney General, below which the merits of a case may be considered by the appropriate United States Attorney.

II. AUTHORIZATION PROCEDURES

A. IN GENERAL

The Secretary may not commence an administrative proceeding in any case until he has notified the Department of Justice of his intent, he has referred the case to the Department

-2-

of Justice, and the Department of Justice has had an opportunity to consider the merits of the case, in accordance with procedures set forth herein.

B. CASES IN WHICH THE TOTAL ASSESSMENT WOULD BE WITHIN THE DELEGATED AUTHORITY OF THE UNITED STATES ATTORNEY

The Secretary may not commence an administrative proceeding until the case has been referred to the United States Attorney and:

1. The United States Attorney declines both civil and criminal prosecution; or
2. The United States Attorney authorizes the Secretary to do so.

C. CASES IN WHICH THE TOTAL ASSESSMENT WOULD EXCEED THE DELEGATED AUTHORITY OF THE UNITED STATES ATTORNEY

The Secretary may not commence an administrative proceeding until:

1. (a) The case has been referred to the United States Attorney for criminal prosecution and (i) prosecution has been declined, or (ii) if prosecution has been accepted, all criminal processes have been completed; and
- (b) (i) The case has been referred to the Civil Division for civil action, and civil action has been declined, or (ii) the Civil Division has been notified of the Secretary's intention to begin administrative proceedings, and the time period specified in section III.A. has expired;

or

- I. The case has been referred under the two preceding paragraphs and both the United States Attorney and the Civil Division authorize the Secretary to commence an administrative proceeding.

III. VARIOUS PROVISIONS

THE PERIOD FOR CONSIDERATION

~~The~~ Civil Division will respond to notices of intention to ~~begin~~ with administrative proceedings within 60 days ~~from~~ the date of receipt of a case under section II.C.1. (b) (i). ~~The~~ Civil Division will send an acknowledgment to the