NLWJC - Kagan

DPC - Box 030 - Folder 006

Health - Nursing Homes

Health - Nursing homes

U.S. Department of Justice

Office of the Deputy Attorney General

Washington, D.C. 20530

FAX TRANSMISSION SHEET

TO: Elena Kagan

Domestic Policy Council

Phone: 456-5534 **Fax:** 456-2878

FROM: John T. Bentivoglio
Special Counsel for Health Care Fraud

Phone: (202) 514-2707 Fax: (202) 616-1239

DATE: 3/29/99

NUMBER OF PAGES (including this cover sheet): 5

MESSAGE: This should provide some background why DOJ is less enthusiastic about relying on HCFA and state administrative enforcement actions against nursing homes.

Note: The information in this facsimile should be considered confidential.

Citation Search Result Rank 20 of 82 Database
3/23/99 BALTSUN 1B ALLNEWS
3/23/99 Balt. Sun 1B
1999 WL 5177447
(Publication page references are not available for this document.)

The Baltimore Sun

Tuesday, March 23, 1999

LOCAL

GAO report rips health officials; Md. slow to respond to nursing home complaints, audit finds; Other states also cited; Agency waited months to investigate cases, panel on aging is told

Walter F. Roche and David Greene
SUN STAFF

Maryland health officials waited four months to begin investigating a complaint that a nursing home patient was so poorly cared for that his body was covered with sores and his hands and fingernails were caked with blood.

The case of the unnamed patient who had been in the nursing home for just under three weeks, was among several noted yesterday in a highly critical federal report on the way Maryland and other states have responded to complaints about poor care in nursing homes.

Members of the Special Committee on Aging yesterday also heard the tearful testimony of a former Baltimore resident who got virtually no response when she complained to Maryland health officials about the "negligent" care provided to her late grandmother in a Parkville nursing home. Gloria Cruz, who now lives in Delaware, said she was told by a Maryland official that we "deal with the live residents before we deal with the dead ones."

The report prepared for the committee by the U.S. General Accounting Office, cites Maryland and other states for not only failing to promptly investigate complaints, but also for understating the seriousness of complaints and setting up procedures that may limit and discourage the filing of complaints in the first place.

In the Baltimore area alone, federal auditors found that 101 pending complaints involving 56 area nursing homes had not even been assigned to an investigator. Those complaints, in some cases, were as much as nine months old.

Maryland officials do not dispute the findings, but say they have taken steps to address the problems. They also contend that federal

3/23/99 BALTSUN 1B
(Publication page references are not available for this document.)

rules have forced state inspectors to devote most of their time to other issues, such as closely policing and closing, if necessary, facilities with persistent problems.

The 22-page GAO report states that an ambulance attendant filed a complaint with the Maryland health department after transporting a patient from a nursing home to a hospital because of the patient's "unprecedented rapid decline."

The patient "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," the report states.

Although they ultimately determined that the nursing home had harmed the patient, state officials had put the complaint in a low priority category and had not begun the investigation until four months after it was filed.

Cruz testified that she complained to the state after her grandmother was released from a nursing home in extremely poor health. Laboratory tests later showed the patient had critically low levels of sodium. Cruz said her grandmother, Elsie Wagner, died on Oct. 16 of last year, a week after her release from the nursing home.

Cruz said she finally got a letter on Saturday from the state, acknowledging that her complaint -- now several months old -- was being investigated.

"I am pursuing this because I don't want my grandmother's death to be in vain," she testified. She added that she told state officials that if they looked into the complaints involving dead people, they might save lives.

In other findings specifically relating to Maryland, the GAO said a state official acknowledged that complaints were downgraded in severity due to manpower problems. Under state procedures the most serious complaints must be investigated within two days.

"A Maryland official acknowledged reducing the priority of some complaints because the state recognized that it could not meet shorter time frames because of insufficient staff," the report states.

The GAO auditors noted that during the one-year review period ending in June 1998, Maryland didn't rank a single complaint in the highest priority category. Nearly half of the 642 complaints were ranked at the lowest priority. As a result, they were not investigated until the next time the state made a regularly scheduled

3/23/99 BALTSUN 1B
(Publication page references are not available for this document.)

inspection.

Other complaints that Maryland officials classified in low-priority categories but which resulted in harm to patients include:

A patient who had to be hospitalized after an intravenous tube was improperly inserted and missed a vein.

A patient who suffered a broken jaw due to improper supervision was placed on intravenous feeding, eventually contracted pneumonia and had to be hospitalized.

Three patients in one facility who had sores, some exposing bone, due to improper care and nutrition. All three had to be hospitalized.

The state, according to the report, didn't investigate the first case until 139 days after the complaint had been filed, while the response time for the other cases ranged from 39 to 130 days.

Auditors also said Maryland's practice of urging residents to put complaints in writing may discourage future complaints. They said state officials gave conflicting information on whether or not complaints that were not in writing were ever investigated.

In addition to Maryland, GAO officials conducted reviews of complaint handling in Michigan and Washington. They also looked at state audits in 11 other states for comparison. The auditors also faulted the federal Health Care Financing Administration for failing to make complaint investigation a high priority and not providing states with proper guidance.

"Serious complaints alleging that nursing home residents are being harmed can remain uninvestigated for weeks or months," the report concludes. "Such delays can prolong situations in which residents may be subject to abuse, neglect resulting in serious care problems."

In a two-page written response to the audit, Carol Benner, director of the division of licensing and certification in the Maryland health department, blamed the delays on staff shortages and mixed signals from federal officials at HCFA.

Benner said a series of "seemingly well intentioned" initiatives by the Clinton Administration "had a direct and palpable impact on Maryland's survey activities." She said mandates from HCFA to focus enforcement on "problem" nursing homes coupled with a small staff forced the agency to assign fewer resources to responding to

3/23/99 BALTSUN 1B
(Publication page references are not available for this document.)

complaints.

"While we make every effort possible to prevent annual or complaint survey delays, we nonetheless recognize that delays inevitably occurred," Benner wrote in the response.

Benner said that her agency already had noted the delays and "began corrective action on several fronts" including the assignment of additional staffers. She said the changes were reducing both the backlog of complaints and the response time to new complaints.

TABULAR OR GRAPHIC MATERIAL SET FORTH IN THIS DOCUMENT IS NOT DISPLAYABLE

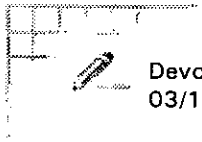
Credit:

---- INDEX REFERENCES ----

EDITION: FINAL

Word Count: 1034
3/23/99 BALTSUN 1B
END OF DOCUMENT

Health - nursing homes



Devorah R. Adler
03/18/99 02:55:00 PM

Record Type: Record

To: Laura Emmett/WHO/EOP

cc: Karin Kullman/OPD/EOP
Subject: nursing home guidance

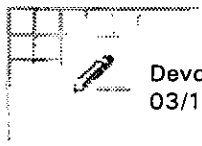
apparently the press office was asking for this -- pls call with questions -- Courtney, can you have Elena clear this, please? thanks -- Devorah

Q: The GAO released several reports on Thursday that criticize HHS for lax oversight of state nursing home complaint investigations and insufficient penalties for facilities that are out of compliance. What is your response?

A: I have always demanded that states investigate all serious complaints promptly to ensure that residents are safe and well-cared for. Last July, I initiated a new nursing home quality initative that ensures swift and strong penalties for nursing homes failing to comply with standards, strengthened oversight of state enforcement mechanisms, and implemented unprecedented efforts to improve nutrition and prevent bed sores. I also invested over $60 million in his FY 2000 budget to support these new efforts.

However, we know that some states haven't taken their oversight responsibility seriously enough. On Thursday, I took strong new steps to address this problem, requiring States to investigate any complaint that alleges harm to a nursing home resident within 10 working days, requiring states to report all of these complaints to HHS' national database, creating a $1,000 minimum fine for facilities violating quality standards, and making it easier for states to impose fines of up to $10,000 for quality violations.

Health- nursing homes



Devorah R. Adler
03/17/99 02:38:51 PM

Record Type: Record

To: Laura Emmett/WHO/EOP

cc:
Subject: nursing home meeting

NURSING HOME RESIDENT PROTECTION ACT

SUMMARY OF THE PROPOSED LEGISLATION

The proposed legislation would give DOJ three new tools to combat the failure of nursing homes and other residential health care facilities to treat residents properly. First, it creates criminal sanctions for organizations or individuals who knowingly and willfully engage in a pattern of physical or mental harm to residents. Second, it would create civil penalties that could be imposed on individuals, facility chains, or management companies if they engage in conduct that results in a pattern of physical or mental harm to residents. Third, it would authorize DOJ to seek injunctive relief against these entities or individuals whenever DOJ has reason to suspect that they are engaging in behavior that will result in harm to physical or mental harm to residents. DOJ would have to consult with HHS before invoking its injunctive authority.

OUTSTANDING ISSUES

HHS is primarily concerned about the overlap in enforcement authority that these new provisions would create. As currently drafted, the only area of facility noncompliance that would not pose the problem of overlapping authority for both agencies would be those cases where violations are minimal or where the harm to residents is isolated. HHS is concerned that in situations where both agencies have an interest in initiating an enforcement action, DOJ will push HCFA to delay its enforcement action, since DOJ's need to build a solid case for conviction may not coincide with HCFA's need to act swiftly when needed. In addition, HHS is concerned that DOJ will develop its own quality standards for individual facilities and chains when deciding whether to initiate prosecution, thus requiring facilities to comply with one set of standards developed by HCFA and another set of standards developed by DOJ.

what are HCFA sanctions

DOJ feels that the overlap in enforcement authority is limited to enforcement action in individual facilities. Currently, no one has the authority to prosecute nursing home chains for repeated violations, which this statute would provide to DOJ. In addition, this policy would not preclude HHS from taking any action to protect the health and safety of residents, and DOJ is willing to codify this in an MOU.

17

PROPOSED DPC POSITION

Modify the DOJ proposal to limit their new enforcement authority to criminal violations and require HHS to propose new legislation providing them with new authority to impose civil

penalties. Under this option, the Department of Justice would be allowed to impose new criminal penalties on individuals, facility chains, and management companites who knowingly and willfully engage in a patterns of physical or mental harm to residents. HHS would propose new legislation creating civil penalties that could be imposed on individuals, facility chains, or management companies if they engage in conduct that results in a pattern of physical or mental harm to residents. This compromise provides virtually the same level of enforcement and eliminates the problematic overlap of authority created by the DOJ proposal.

Health-nursing homes

Leanne A. Shimabukuro 03/23/99 12:21:55 PM

Record Type: Record

To: Elena Kagan/OPD/EOP, Christopher C. Jennings/OPD/EOP, Devorah R. Adler/OPD/EOP, Sarah A. Bianchi/OVP @ OVP

cc:
Subject: Crime Bill -- Nursing Home Provision

FYI

---------- Forwarded by Leanne A. Shimabukuro/OPD/EOP on 03/23/99 12:24 PM ----------

Ronald E. Jones 03/23/99 11:01:14 AM

Record Type: Record

To: See the distribution list at the bottom of this message

cc:
Subject: Crime Bill -- Nursing Home Provision

---------- Forwarded by Ronald E. Jones/OMB/EOP on 03/23/99 10:56 AM ----------

Gaylee L. Morgan 03/23/99 09:58:35 AM

Record Type: Record

To: Ronald E. Jones/OMB/EOP@EOP

cc: See the distribution list at the bottom of this message
Subject: Crime Bill -- Nursing Home Provision

HD staff have reviewed Section 3039 of the Crime Bill ("Nursing Home Resident Protection Act") and have the following comments:

Inclusion in Crime Bill. As a matter of perception, we believe there is a danger in housing a nursing home quality provision in the crime bill. Nursing home resident advocates have raised concerns that nursing home enforcement should, in general, be a quality issue, not a crime issue. ***We recommend pulling the nursing home provision out of the crime bill and sending it up as a stand-alone bill.***

Criminal Authority for DOJ. ***We concur with the provisions in the bill that would give DOJ criminal authority over both nursing home chains and individual nursing homes.***

Referral. The bill would give DOJ the authority to pursue nursing homes without referral from HCFA. We believe this would create significant overlap between HCFA's and DOJ's enforcement

actions and could impede HCFA's actions to improve quality. We are also concerned that, because DOJ would exercise its authority through its US Attorney's offices, there would not be a consistent application of quality standards. ***We recommend that DOJ have the authority to pursue nursing homes only upon referral from HCFA or with the explicit approval of HCFA. We believe these provisions should be included as part of the actual bill, rather than as an MOU.***

Chains vs. Individual Facilities. The bill would give DOJ civil authority to pursue both nursing home chains and individual facilities. ***We believe HCFA should have primary civil authority in cases involving individual facilities, and we recommend removing the legislative language that gives DOJ civil authority over individual facilities.*** DOJ would continue to have civil authority through the False Claims Act, upon referral from HCFA. DOJ's proposal would impede HCFA's ability to enforce quality through CMPs, including the use of HCFA's new CMP per-instance CMP authority. For nursing home chains, ***we believe DOJ should have civil authority to pursue nursing home chains only upon referral from HCFA or with the explicit approval of HCFA.***

Protecting Enforcement of Quality. The bill provides no assurance that HCFA will be allowed to continue quality enforcement actions even if DOJ is conducting its own investigation. We believe HCFA should be able to continue its enforcement actions even if DOJ is conducting its own investigation. ***We recommend including language stating that "Nothing in this Act shall be construed as depriving the Secretary of Health and Human Services of any authority, including enforcement authorities, under the Social Security Act, related to nursing homes."***

As you know, negotiations among policy officials at HHS, HCFA, DOJ, OMB and DPC are ongoing. We understand that there is a tentative agreement between HCFA and DOJ that would give HCFA veto authority over injunctive relief cases brought by DOJ in exchange for giving DOJ civil authority over individual nursing homes, with required advance consultation with HCFA.

We suggest two possible alternatives:

- Accept this compromise as is, but insert language stating that "Nothing in this Act shall be construed as depriving the Secretary of Health and Human Services of any authority, including enforcement authorities, under the Social Security Act, related to nursing homes." This would protect HCFA's efforts to enforce quality even if DOJ is conducting its own investigation.
- Give all primary civil authority to HCFA, but establish a referral process in an MOU for both chains and individual facilities.

Please let us know if you have any questions.

Message Copied To:

Daniel N. Mendelson/OMB/EOP@EOP
Mark E. Miller/OMB/EOP@EOP
Barry T. Clendenin/OMB/EOP@EOP
Robert J. Pellicci/OMB/EOP@EOP
Anne E. Tumlinson/OMB/EOP@EOP
Caroline B. Davis/OMB/EOP@EOP
Yvette Shenouda/OMB/EOP@EOP
Gina C. Mooers/OMB/EOP@EOP

Message Sent To:

Health - nursing home

PRESIDENT CLINTON: IMPROVING THE QUALITY OF NURSING HOME CARE

July 21, 1998

"Moving a parent to a nursing home is one of life's most difficult decisions. But with these steps, we are giving families the security of knowing that we are doing everything we can to make our nation's nursing homes safe and secure."

President Bill Clinton
July 21, 1998

Today, President Clinton announces tough new legislative and administrative actions to improve the quality of nursing homes and crack down on nursing homes that do not follow the rules. These actions include:ensuring swift and strong penalties for nursing homes failing to comply with standards, strengthening oversight of state enforcement mechanisms, developing a national registry to track and identify individuals with a record of abusing residents, and implementing unprecedented efforts to improve nutrition and prevent bed sores.

THE NEED TO ENSURE QUALITY CARE IN NURSING HOMES. There are approximately 1.6 million older Americans and people with disabilities that receive care in roughly 16,700 nursing homes nationwide. Problems like the inappropriate use of physical restraints and a shortage of hearing aids for those in need were reduced by the enactment of new regulations by the Health Care Financing Administration (HCFA) in 1995. However, HCFA's ongoing review of nursing home care, and a report being sent to Congress today by the Department of Health and Human Services (HHS), shows that tougher enforcement is needed to ensure high quality care in all nursing homes.

A PRESIDENTIAL PLAN TO IMPROVE NURSING HOME CARE. This week, the President is sending Congress tough new legislation that calls for:

- **Nursing Homes To Conduct Criminal Background Checks On All Potential Employees;**
- **The Establishment Of A National Abuse Registry To Keep Track Of Those Convicted Of Abusing Residents;**
- **Improving Nutrition and Hydration Therapy By Allowing More Categories Of Nursing Home Employees To Perform These Functions**
- **Reauthorization Of The Nursing Home Ombudsman Program Run By The Administration On Aging.**

NEW ADMINISTRATIVE ACTIONS TO IMPROVE THE QUALITY OF NURSING HOMES. Today, the President is also announcing the implementation of new penalties, inspections, and tougher oversight of nursing homes by the HCFA, including:

- Immediate Civil Monetary Penalties Against Nursing Homes That Violate Federal Standards;
- Tougher Nursing Home Inspections, including: (1) Staggered survey times to prevent inadequate nursing homes from preparing for inspections; (2) Targeting nursing home chains with bad records; (3) Cooperative efforts with the HHS Office of the Inspector General and the Department of Justice to refer severe violations of quality care standards for criminal investigation and prosecution where appropriate;
- Stronger Federal Enforcement Of State Nursing Home Oversight and tougher actions against those states that are failing to enforce standards. The HCFA will: (1) Terminate federal nursing home inspection funding to states with consistently poor records; (2) Increase oversight of state inspections; (3) Ensure that nursing homes are in compliance with standards before lifting sanctions;
- Publishing Nursing Home Survey Results On The Internet;
- Preventing Bed Sores, Dehydration, and Malnutrition by requiring state surveyors to monitor actions taken by nursing homes to prevent these ailments;
- Implementing New Efforts To Measure And Monitor Nursing Home Quality. This month, the HCFA began collecting information on resident care through a national automated data system that will be analyzed to identify potential areas of inadequate care in nursing homes and to assess performance in critical areas.

Health - nursing homes

THE WHITE HOUSE

WASHINGTON

July 20, 1998

NURSING HOME ANNOUNCEMENT

DATE:	July 21, 1998
LOCATION:	Oval Office
BRIEFING TIME:	2:30 pm
EVENT TIME:	3:00 pm
FROM:	Bruce Reed/Chris Jennings

I. PURPOSE

To highlight your commitment to improve the quality of nursing homes by announcing tough new legislative and administrative actions.

II. BACKGROUND

There are approximately 16,800 nursing homes in the United States, serving 1.6 million people. Since HCFA put new regulations in place in 1995, the health and safety of nursing homes has improved. But Senator Grassley will unveil a report next week on the shortcomings in nursing home care, and HCFA will transmit a report to Congress tomorrow concluding that tougher enforcement is needed to ensure high quality in all nursing homes. You will respond to both of these reports with a tough new initiative to crack down on bad apple nursing homes and ensure high quality care.

New Legislation to Improve the Quality of Nursing Homes.
You will announce that you are transmitting legislation to the Hill this week that calls for:

- **New Criminal Background Checks.** An important way to improve the quality of nursing homes is to prevent inadequate personnel from entering the system in the first place. The legislation you will propose would require nursing homes to conduct criminal background checks on all potential personnel.

- **National Abuse Registry.** Once inadequate personnel have been identified, they should be kept out of the system. The new legislation will ask Congress to establish a national registry of nursing home employees convicted of abusing residents.

- **Nutrition and Hydration Therapy.** Currently, too few nursing home staff are available to help feed residents. To improve nutrition in nursing homes, you will

ask Congress to allow more categories of nursing home employees to perform crucial nutrition and hydration functions.

- **Reauthorization of the Nursing Home Ombudsman Program.** You also will call on Congress to reauthorize the nursing home ombudsman program run by the Administration on Aging, which provides consumers with critical information on poor-quality nursing homes, including records of abuse and neglect.

New Administrative Actions To Improve the Quality of Nursing Homes.
You will announce new administrative actions that HCFA will implement immediately, including:

- **Immediate Civil Monetary Penalties in Nursing Homes That Violate Federal Standards.** To crack down on inadequate providers, HCFA will direct enforcement authorities to impose civil monetary penalties immediately upon finding a serious or chronic violation. Under current practice, enforcement officials often give nursing homes a second chance to come into compliance, rather than impose immediate sanctions.

- **Tougher Nursing Home Inspections.** Starting today, HCFA will take several steps to strengthen states' inspection of nursing homes, such as:

  -- Staggering survey times: The report that HCFA is transmitting to Congress finds that nursing home inspections are too predictable, allowing inadequate homes to prepare for inspections. Enforcement officials will now stagger survey times and conduct some surveys on weekends and evenings.

  -- Targeting chains with bad records: Federal and State officials will target nursing home chains that have a poor record of compliance with the Federal regulations for additional inspections.

  -- Increasing criminal investigations: HCFA also will work with the HHS Office of Inspector General and Department of Justice to refer egregious violations of quality of care standards for criminal investigation and prosecution when appropriate.

- **Stronger Federal Oversight of State Inspections.** HCFA will increase its oversight of state surveyors, review and monitor nursing homes with greater consistency, and take new tough actions against those states that are failing to adequately enforce standards. It will:

  -- Terminate Federal nursing home inspection funding to states with continual poor records. The report being released by HCFA finds that some states have cited few or no nursing homes for substandard care. In

states where oversight is clearly inadequate, HCFA will terminate state contracts and contract with other entities to conduct Federally-approved inspections.

-- Increase oversight of state inspections. HCFA will increase its review of the surveys conducted by the states to ensure thorough oversight, as well as provide additional training and other assistance to state enforcement officials.

-- Ensure that nursing homes are in compliance with standards before lifting sanctions. HCFA will increase oversight of state enforcement officials to ensure that they will not lift sanctions until after an on-site visit has verified compliance.

- **Preventing Bed Sores, Dehydration, and Malnutrition.** HCFA will implement new oversight to ensure that nursing homes take actions to prevent bed sores, dehydration, and malnutrition. State surveyors will be required to monitor these activities, and sanction nursing homes with patterns of violations. HCFA also will work with the Administration on Aging, the American Dieticians Association, clinicians, consumers, and nursing homes to develop best practice guidelines to prevent malnutrition and dehydration.

- **Publishing Survey Results on the Internet.** To increase accountability and flag repeat offenders for families and the public, HCFA will, for the first time, post individual nursing home survey results on the Internet.

- **Implementing New Efforts to Measure and Monitor Nursing Home Quality.** In June 1998, HCFA began collecting information on resident care through a national automated data system, known as Minimum Data Sets. This information will be analyzed to identify potential areas of inadequate care in nursing homes and to assess performance in critical areas, such as nutrition, avoidable bed sores, loss of mobility, and use of restraints. This assessment will help HCFA and state surveyors to identify nursing homes for immediate on-site inspections and to detect and correct problems earlier.

III. PARTICIPANTS

Briefing Participants:
Secretary Shalala
Bruce Reed
Chris Jennings

Participants:
Secretary Shalala
Members of senior citizen organizations

IV. PRESS PLAN

Pool Press.

V. SEQUENCE OF EVENTS

- Secretary Shalala will make remarks and introduce **YOU**.
- **YOU** will deliver a statement.
- **YOU** may answer questions from the pool, and then depart.

VI. REMARKS

Remarks Provided by Speechwriting.