Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

CMS Can Do More To Leverage Medicare Claims Data To Identify Unreported Incidents of Potential Abuse or Neglect

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Office of Inspector General

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Report in Brief
Date: November 2023
Report No. A-01-22-00501

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

CMS Can Do More To Leverage Medicare Claims Data To Identify Unreported Incidents of Potential Abuse or Neglect

Why OIG Did This Audit

We previously conducted an audit of CMS's use of Medicare data to identify incidents of potential abuse or neglect and found that CMS did not use Medicare claims data to identify incidents of abuse or neglect of Medicare enrollees. CMS did not concur with three of our four prior audit recommendations.

Our objectives were to determine: (1) the prevalence of incidents of potential abuse or neglect of Medicare enrollees for 2019 and 2020, (2) who may have perpetrated those incidents and where they occurred, and (3) whether the incidents were reported to law enforcement.

How OIG Did This Audit

Our audit covered claims from January 2019 through December 2020 for services provided to treat Medicare enrollees with diagnosis codes related to abuse or neglect. We sampled 100 Medicare claims and reviewed the medical records to determine whether they contained evidence of potential abuse or neglect, who perpetrated those incidents, where they occurred, and whether law enforcement was alerted. We also discussed with CMS the reasons for its nonconcurrence with our prior recommendations.

What OIG Found

We identified 30,258 Medicare claims for services provided from January 1, 2019, through December 31, 2020, that contained diagnosis codes indicating the treatment of injuries potentially caused by abuse or neglect of Medicare enrollees. Of the 100 Medicare claims we sampled, 93 had medical records that contained evidence of potential abuse or neglect. We also determined that of these 93 claims, 14 were allegedly perpetrated by health care workers, 17 were related to incidents that occurred in medical facilities, and 18 were related to incidents that were not reported to law enforcement. On the basis of our sample results, we estimated that 27,522 of the 30,258 Medicare claims we identified from 2019 and 2020 were supported by medical records that contained evidence of potential abuse or neglect. We further estimated that, of the claims in our sampling frame associated with incidents of potential abuse or neglect, 2,320 were allegedly perpetrated by health care workers, 3,546 were related to incidents that occurred in medical facilities, and 7,298 were related to incidents that were not reported to law enforcement.

What OIG Recommends and CMS Comments

We recommend that CMS: (1) conduct data analyses to identify trends and high-risk areas in Medicare claims containing diagnosis codes indicating potential abuse or neglect; (2) provide the results of the analyses to Quality Improvement Organizations and Medicare Program Integrity contractors so that they can conduct targeted claim reviews to identify patterns of unreported incidents of potential abuse or neglect and the reasons the incidents were unreported; (3) based on the results of the targeted claim reviews, develop and share guidance and best practices with providers to help ensure that incidents are reported in compliance with State mandatory reporting laws; and (4) consider the results of targeted claims reviews when assessing whether the existing conditions of participation requirements for reporting abuse or neglect of Medicare enrollees should be strengthened.

CMS concurred with our recommendations and described actions it plans to take to address most of them. For example, CMS stated that it will develop and share guidance with providers on reporting instances of potential abuse or neglect. CMS also stated that it will evaluate all available evidence as it pertains to abuse and neglect when assessing the need for revisions to the existing conditions of participation.

The full report can be found at https://oig.hhs.gov/oas/reports/region1/12200501.asp.

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INTRODUCTION

WHY WE DID THIS AUDIT

The Department of Health and Human Services (HHS), Office of Inspector General (OIG) previously conducted an audit of the Centers for Medicare & Medicaid Services' (CMS's) use of Medicare data to identify incidents of potential abuse or neglect.[1] This audit and our previous audit are both part of a series of audits that addresses the identification, reporting, and investigation of incidents of potential abuse or neglect of our Nation's populations at a higher risk for abuse or neglect, including children, the elderly, and individuals with developmental disabilities.[2] We are committed to detecting and combating such abuse and neglect.

In our previous audit, we found that CMS did not use Medicare claims data to identify incidents of abuse or neglect of people enrolled in Medicare (Medicare enrollees). Accordingly, we recommended that CMS take steps to extract Medicare claims containing diagnosis codes related to abuse or neglect and to inform States that the claims data are available to help ensure that incidents are reported in compliance with State mandatory reporting laws. However, CMS did not concur with three of our four audit recommendations.

Because protecting populations at a higher risk for abuse or neglect is a priority for CMS and OIG, we performed this audit to determine the prevalence of incidents of potential abuse or neglect of Medicare enrollees; to better understand the reasons for CMS's nonconcurrence with our prior recommendations and the obstacles that prevented CMS from implementing them; and, if necessary, to develop revised recommendations to help CMS use Medicare claims data to protect individuals from abuse or neglect.[3]

OBJECTIVES

Our objectives were to determine: (1) the prevalence of incidents of potential abuse or neglect of Medicare enrollees for 2019 and 2020, (2) who may have perpetrated those incidents and where they occurred, and (3) whether the incidents were reported to law enforcement.

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[1] HHS-OIG, *CMS Could Use Medicare Data To Identify Instances of Potential Abuse or Neglect* (A-01-17-00513) June 2019.

[2] See Appendix B for related work.

[3] This audit report includes incidents involving all types of Medicare enrollees, regardless of their age or the reason for their Medicare coverage. The list of diagnosis codes used for this audit report includes only those codes that specifically indicate potential abuse or neglect. For the purpose of this report, an "incident" is defined as a Medicare claim involving the treatment of potential abuse or neglect.

BACKGROUND

The Medicare Program

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 years and older, people with disabilities, and people with end-stage renal disease. CMS administers Medicare. Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge. Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services, physician services, laboratory services, and ambulance services. There was a monthly average of 62.8 million Medicare enrollees in 2020.

The Social Security Act

Section 2011 of the Act provides definitions related to elder justice. "Elder justice" is a term used to describe efforts to "prevent, detect, treat, intervene in, and prosecute elder abuse, neglect, and exploitation." Section 2011 defines abuse as "the knowing infliction of physical or psychological harm or the knowing deprivation of goods or services that are necessary to meet essential needs or to avoid physical or psychological harm." It defines neglect as "the failure of a caregiver or fiduciary to provide the goods or services that are necessary to maintain the health or safety of an elder."[4] It also defines exploitation as "the fraudulent or otherwise illegal, unauthorized, or improper act or process of an individual, including a caregiver or fiduciary, that uses the resources of an elder for monetary or personal benefit, profit, or gain, or that results in depriving an elder of rightful access to, or use of, benefits, resources, belongings, or assets."

Federal Laws and Regulations for Reporting and Investigating Potential Abuse or Neglect

There are several Federal laws and regulations enacted to protect Medicare enrollees from abuse and neglect, including the Older Americans Act, the Elder Justice Act (EJA), and the Medicare and Medicaid Conditions of Participation (CoPs). The Older Americans Act, P.L. No. 89-73 (enacted July 14, 1965), was reauthorized as P.L. No. 114-144 (April 19, 2016) with a variety of objectives, including the protection of older persons from abuse, neglect, and exploitation. The EJA, enacted as part of the Patient Protection and Affordable Care Act (ACA) on March 23, 2010, contains provisions that address certain public health and social service approaches for the prevention, detection, and treatment of elder abuse primarily under HHS's authority and administration.[5] CMS developed the CoPs that health care organizations must meet to participate in Medicare and Medicaid. These CoPs establish health and safety

[4] This definition also includes self-neglect.

[5] P.L. No. 111-148 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, P.L. No. 111-152 (Mar. 30, 2010). Subtitle H of the ACA of 2010 is also known as the EJA of 2009.

standards that are the foundation for improving quality and protecting the health and safety of enrollees. (See Appendix C for additional information about these laws and regulations.)

State Programs for Reporting and Investigating Potential Abuse or Neglect

There are several programs in each State that perform functions related to the reporting and investigating of potential abuse or neglect of Medicare enrollees, including the State Survey Agencies, Medicaid Fraud Control Units (MFCUs), and Adult Protective Services (APS) programs. State Survey Agencies conduct investigations and fact-finding surveys to determine how well health care providers comply with their applicable CoPs, including the reporting of potential abuse or neglect. Each State's MFCU investigates and prosecutes a variety of health care-related crimes, including patient abuse or neglect in health care facilities.[6] Additionally, each State has an APS program authorized by State law. State and local APS programs are considered among the first responders to reports of abuse, neglect, or exploitation of adults.[7] (See Appendix C for additional information about these programs.)

HHS Strategic Plan

HHS's Strategic Plan for fiscal years 2018 through 2022 included several strategic objectives related to the health, safety, and well-being of individuals.[8] For example, Strategic Objective 3.2 was to "safeguard the public against preventable injuries and violence or their results." Two of HHS's strategies to achieve this objective were to: (1) "expand knowledge about important abuse intervention models to enhance evidence-based services for older adults and adults with disabilities" and (2) "assess health care use and costs associated with violence and unintentional injury, including patient safety events that occur in health care settings, to inform actions to prevent injury and violence and describe the return on investment of public health action." HHS's Strategic Plan for fiscal years 2022 through 2026 also contains strategic objectives related to the health, safety, and well-being of individuals.[9] For example, Strategic Objective 3.4 is "to increase safeguards to empower families and communities to prevent and respond to neglect, abuse, and violence, while supporting those who have experienced trauma or violence."

[6] The Act § 1903(q).

[7] Each State defines "adult" differently for APS purposes. For example, some States define an adult eligible for APS services as anyone aged 18 years or older, but other States define such an adult as anyone aged 60 years or older. Some States also require that the adults have been diagnosed with a physical or mental illness or a disability.

[8] HHS, *HHS Strategic Plan Fiscal Years 2018 - 2022*. Available online at https://dhhs.info/about/strategic-plan/2018-2022/index.html. Accessed on Aug. 7, 2023.

[9] HHS, *HHS Strategic Plan Fiscal Years 2022 - 2026*. Available online at https://www.hhs.gov/about/strategic-plan/2022-2026/index.html. Accessed on Aug. 7, 2023.

Mandatory Reporting

All States require certain individuals by law to report suspected abuse, neglect, or exploitation of elderly or other adults at risk for abuse or neglect to APS. This is referred to as "mandatory reporting," and those required to make the reports are referred to as "mandatory reporters." Some States require only certain professionals to report suspected abuse, neglect, or exploitation. Other States require all citizens to report suspected abuse, neglect, or exploitation.

Quality Improvement Organization Program

The Quality Improvement Organization (QIO) Program, as required by sections 1152-1154 of the Act, is dedicated to improving the quality of care for Medicare enrollees and is an integral part of HHS's National Quality Strategy for providing better care and better health at a lower cost. A QIO is a group of health quality experts, clinicians, and consumers that work under the direction of CMS in support of the QIO Program. There are two types of QIOs: Beneficiary and Family Centered Care (BFCC) QIOs and Quality Innovation Network (QIN) QIOs. BFCC-QIOs manage all beneficiary complaints and quality of care reviews to ensure consistency in the review process while taking into consideration local factors important to beneficiaries and their families. QIN-QIOs bring Medicare enrollees, providers, and communities together in data-driven initiatives that increase patient safety, make communities healthier, better coordinate post-hospital care, and improve clinical quality.

Medicare Integrity Program

The Medicare Integrity Program was established by section 1893 of the Act to prevent, detect, and combat fraud, waste, and abuse in the Medicare program. To help achieve this goal, CMS procures contractors to conduct certain program integrity activities. These contractors include Unified Program Integrity Contractors, Medicare Administrative Contractors, and Supplemental Medical Review Contractors. The focus of these contractors is to ensure compliance with Medicare regulations, refer suspected fraud and abuse to law enforcement, or recommend revocation of providers that are noncompliant with Medicare regulations and policies.[10]

Findings From Our Related Prior OIG Audit

In our previous audit, we found that CMS did not identify Medicare claims that indicated potential abuse or neglect because it did not extract data consisting of Medicare claims containing diagnosis codes related to abuse or neglect. Specifically, we identified 34,664 Medicare claims that contained diagnosis codes indicating the treatment of injuries potentially caused by abuse or neglect of Medicare enrollees from January 1, 2015, through June 30, 2017.

[10] CMS, Medicare Program Integrity Manual, chapter 4, § 4.1. Available online at https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/pim83c04.pdf. Accessed on Aug. 7, 2023.

We estimated that 30,754 of these Medicare claims were supported by medical records that contained evidence of potential abuse or neglect. We further estimated that, of the claims in our population associated with incidents of potential abuse or neglect, 2,574 were allegedly perpetrated by health care workers, 3,330 were related to incidents that occurred in medical facilities, and 9,294 were related to incidents that were not reported to law enforcement.[11]

Accordingly, we recommended that CMS: (1) compile a complete list of diagnosis codes that indicate potential physical or sexual abuse and neglect; (2) use that complete list to conduct periodic data extracts of all Medicare claims containing at least one of those codes; (3) inform States that the extracted Medicare claims data are available to help States ensure compliance with their mandatory reporting laws; and (4) assess the sufficiency of existing Federal requirements, such as CoPs and section 1150B of the Act, to report suspected abuse and neglect of Medicare enrollees, regardless of where services are provided, and strengthen those requirements or seek additional authorities as appropriate. In written comments on our draft report, CMS concurred with our fourth recommendation but did not concur with our first three recommendations. Specifically, CMS stated that claims data may not be timely enough to address acute problems in identifying and addressing potential abuse or neglect of Medicare enrollees. We respectfully disagreed with CMS's comments.

HOW WE CONDUCTED THIS AUDIT

Our audit covered 30,258 inpatient and outpatient claims totaling $138 million for services provided to Medicare enrollees from January 2019 through December 2020 (audit period) to treat enrollees with at least 1 of 64 diagnosis codes related to abuse or neglect.[12] We included these 64 diagnosis codes because their descriptions specifically indicate potential physical abuse, sexual abuse or rape, neglect or abandonment, or other maltreatment. We selected a stratified random sample of 100 Medicare claims and then reviewed the associated medical records to determine whether they contained evidence of potential abuse or neglect. If the medical record contained evidence of potential abuse or neglect, we then determined who may have perpetrated those incidents, where they occurred, and whether law enforcement was alerted. We also discussed with CMS officials the reasons for its nonconcurrence with our prior recommendations and the obstacles associated with implementing our recommendations to extract Medicare claims and make the data available to States.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain

[11] For the purpose of this report, we use the term "law enforcement" to refer to local law enforcement and APS programs that are authorized by State law to receive reports of abuse, neglect, or exploitation of adults.

[12] These 64 diagnosis codes were assigned by the physicians who treated the Medicare enrollees. We could not identify Medicare enrollees who were injured but not treated by a physician because there would have been no record of their treatment. Therefore, there is a risk that other Medicare enrollees who were potentially abused or neglected remain unidentified.

sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology. Appendix D contains our statistical sampling methodology. Appendix E contains our sample results and estimates. Appendix F details the total number of claims associated with each of the 64 diagnosis codes related to abuse or neglect.

FINDINGS

We identified 30,258 Medicare claims for services provided from January 1, 2019, through December 31, 2020, that contained diagnosis codes indicating the treatment of injuries potentially caused by abuse or neglect of Medicare enrollees. Of the 100 Medicare claims we sampled, 93 had medical records that contained evidence of potential abuse or neglect. We also determined that of these 93 claims, 14 were allegedly perpetrated by health care workers, 17 were related to incidents that occurred in medical facilities, and 18 were related to incidents that were not reported to law enforcement. On the basis of our sample results, we estimated that 27,522 of the 30,258 Medicare claims we identified from 2019 and 2020 were supported by medical records that contained evidence of potential abuse or neglect. We further estimated that, of the claims in our sampling frame associated with incidents of potential abuse or neglect, 2,320 were allegedly perpetrated by health care workers, 3,546 were related to incidents that occurred in medical facilities, and 7,298 were related to incidents that were not reported to law enforcement. CMS did not identify similar incidents of potential abuse or neglect during our audit period because it did not compile a list of diagnosis codes related to abuse or neglect and did not extract data consisting of Medicare claims containing at least one of those codes as we previously recommended.

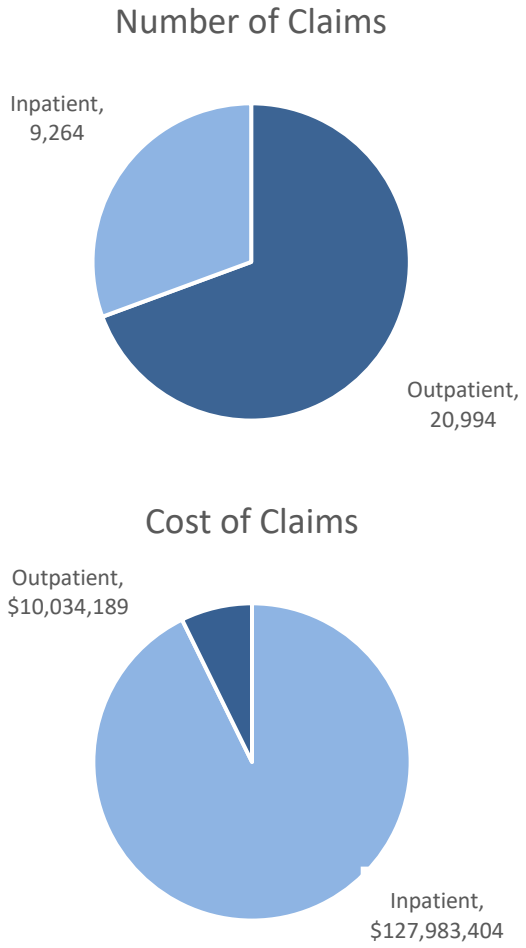
MEDICARE CLAIMS DATA IDENTIFIED MANY INCIDENTS OF POTENTIAL ABUSE OR NEGLECT, AND MOST SAMPLED MEDICAL RECORDS CONTAINED EVIDENCE OF POTENTIAL ABUSE OR NEGLECT

Medicare Claims Data Identified More Than 30,000 Incidents of Potential Abuse or Neglect

We identified 30,258 Medicare claims during our audit period that contained diagnosis codes indicating the treatment of injuries potentially caused by abuse or neglect of Medicare enrollees. The incidents of potential abuse or neglect were indicated on these Medicare claims by the use of at least 1 of 64 diagnosis codes that indicate abuse or neglect. These claims related to 24,261 Medicare enrollees who received medical treatment during our audit period at a variety of medical facilities in all 50 States, the District of Columbia, and U.S. territories. Of the 24,261 Medicare enrollees, 3,516 had more than 1 claim related to abuse or neglect. In addition, 466 of these Medicare enrollees died at a medical facility during the treatment of their injuries.

Most of the 30,258 Medicare claims were for treatment provided in outpatient settings (69 percent), and the remaining claims were for treatment provided in inpatient settings (31 percent). The total cost of the 20,994 outpatient claims for the treatment of the Medicare enrollees' injuries was $10,034,189, an average of $478 per claim; the total cost of the 9,264 inpatient claims for the treatment of the Medicare enrollees' injuries was $127,983,404, an average of $13,815 per claim (Figure 1).

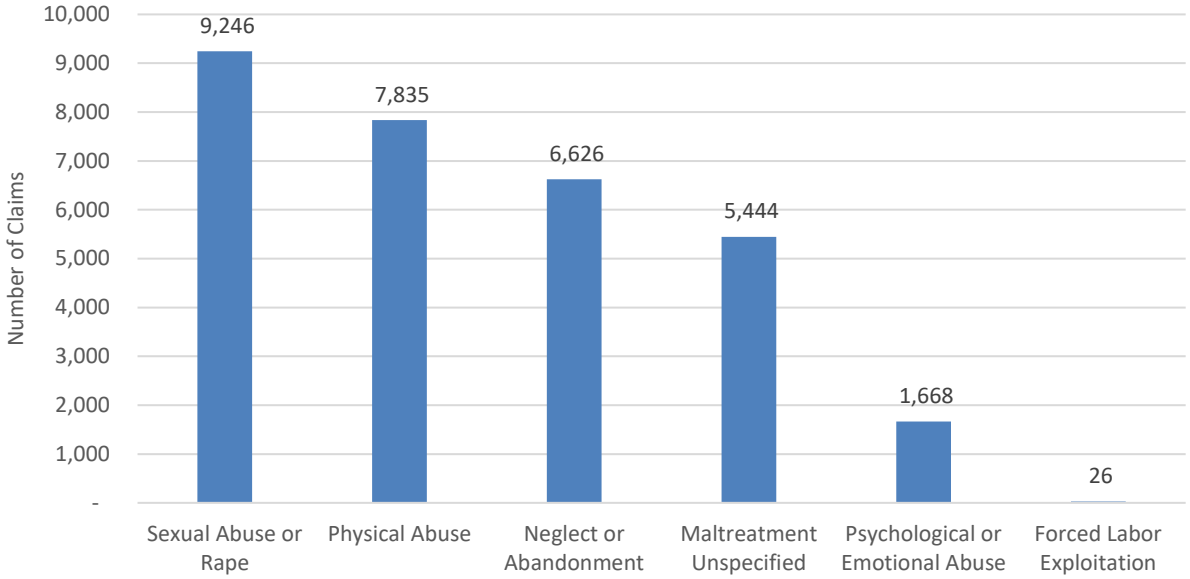
Figure 1: Inpatient and Outpatient Medicare Claims Associated With Potential Abuse or Neglect That Were Submitted by the Treating Facilities



On the basis of their descriptions, we categorized the 64 diagnosis codes into 6 categories: (1) sexual abuse or rape, (2) physical abuse, (3) neglect or abandonment, (4) maltreatment unspecified, (5) psychological or emotional abuse, and (6) forced labor exploitation. Figure 2 (on the next page) details the number of claims for each of these 6 categories.[13]

[13] The total number of claims in Figure 2 is greater than 30,258 because 587 claims had more than 1 diagnosis code indicating potential abuse or neglect associated with the claims.

Figure 2: Claims by Diagnosis Category



Using the claims data, we also reviewed demographic data such as the individual's age at the time of the claim and the individual's sex. The ages of enrollees (Figure 3) were broadly distributed despite the fact that most Medicare enrollees are older than age 65. Specifically, 49 percent of claims in our sampling frame were for Medicare beneficiaries younger than 65 years old, and 51 percent were for Medicare beneficiaries at least 65 years old at the time of the claim. In addition, female enrollees had the majority (78 percent) of abuse or neglect claims (Figure 4 on the next page).

Figure 3: Ages of Enrollees

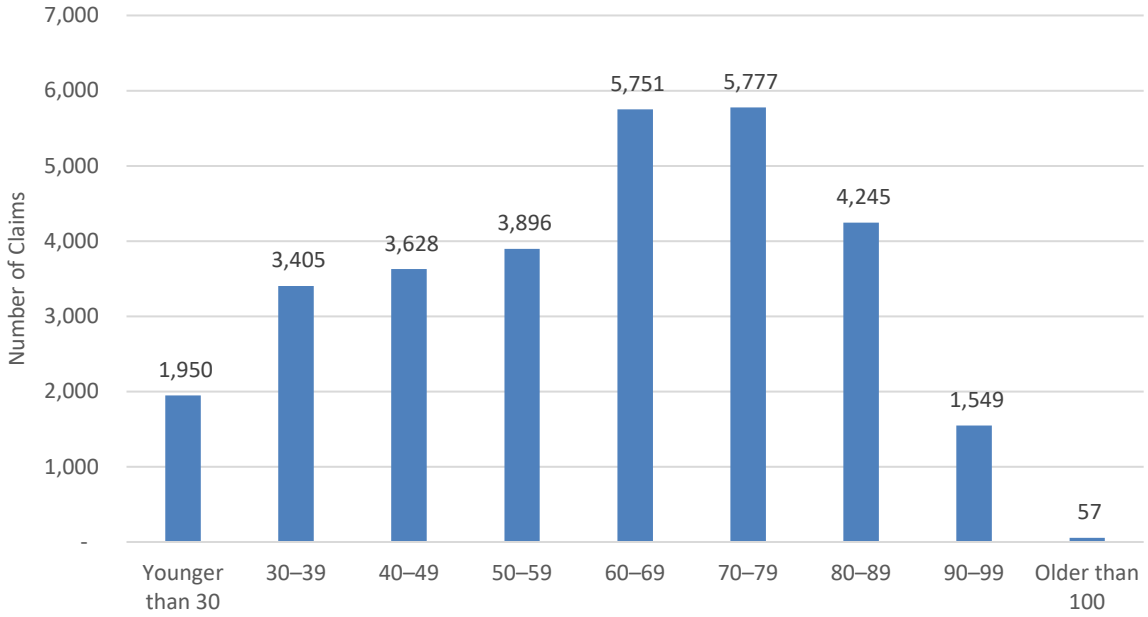
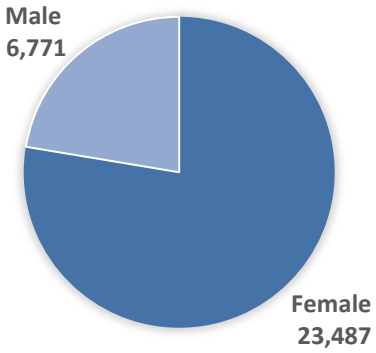


Figure 4: Sex of Enrollees



More Than 90 Percent of Sampled Medical Records Contained Evidence of Potential Abuse or Neglect

Of the 100 Medicare claims we sampled, 93 had medical records that contained evidence of potential abuse or neglect. This evidence included, but was not limited to, witness statements and photographs. We were unable to determine whether the remaining seven Medicare claims were for treatment of injuries as a result of potential abuse or neglect because of insufficient or unclear documentation in the medical records. On the basis of our sample results, we estimated that 27,522 of the 30,258 Medicare claims in our sampling frame had medical records that contained evidence of potential abuse or neglect. For the remainder of this report, when we mention the claims sampled, we will refer to the 93 claims associated with incidents of potential abuse or neglect as shown in their medical records in our sample of 100 claims.

HEALTH CARE WORKERS WERE SOMETIMES THE ALLEGED PERPETRATORS OF INCIDENTS OF POTENTIAL ABUSE OR NEGLECT, AND MOST INCIDENTS OCCURRED IN SETTINGS OTHER THAN MEDICAL FACILITIES

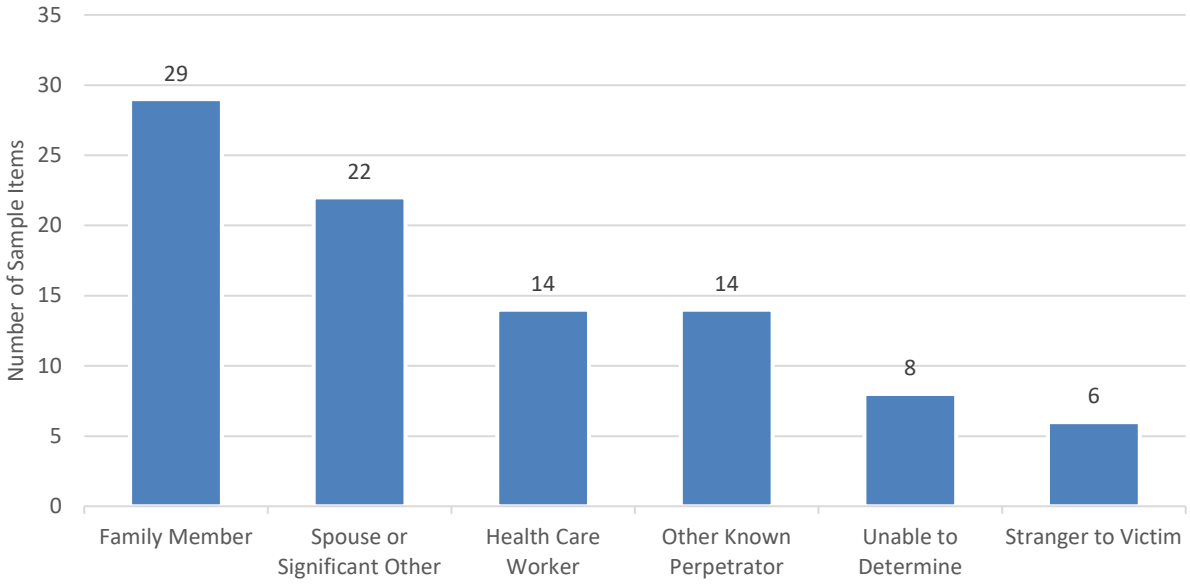
Health Care Workers Were Sometimes the Alleged Perpetrators of Incidents of Potential Abuse or Neglect

Some of the incidents of potential abuse or neglect associated with the Medicare claims we reviewed involved alleged perpetrators who were health care workers. Specifically, we determined that for 14 of the 93 Medicare claims in our sample that contained evidence of potential abuse or neglect, the alleged perpetrators were health care workers. On the basis of our sample results, we estimated that 2,320 of the 30,258 Medicare claims in our sampling frame were associated with incidents of potential abuse or neglect in which the alleged perpetrators were health care workers.[14]

[14] The 90-percent confidence interval for the number of Medicare claims in our sampling frame that were associated with incidents of potential abuse or neglect in which the alleged perpetrators were health care workers was 625 to 4,015.

Of the 93 Medicare claims associated with incidents of potential abuse or neglect in our sample, 29 were associated with incidents involving family members, 22 involved spouses or significant others, 14 involved other known alleged perpetrators (e.g., an acquaintance or self-abuse), and 6 were incidents with an alleged perpetrator who was a stranger to the victim. We were unable to determine who the alleged perpetrator was for the remaining eight Medicare claims in our sample. Figure 5 details the categories of perpetrators for each of the 93 Medicare claims.

Figure 5: Categories of Perpetrators Associated With Incidents of Potential Abuse or Neglect in Our Sample



Most Incidents of Potential Abuse or Neglect Occurred in Settings Other Than Medical Facilities

Section 1150B of the Act and the CoPs contained in the Code of Federal Regulations (CFR) Title 42 for long-term care facilities include reporting requirements for incidents of suspected abuse or neglect.[15] For these facilities, covered individuals are required to report reasonable suspicions of a crime within 2 hours if the incident resulted in serious bodily injury and within 24 hours if the incident did not result in serious bodily injury. The CoPs for hospitals require that hospitals follow State laws for mandatory reporting of suspected abuse, neglect, or exploitation. Group homes and assisted living facilities are covered by State regulations regarding the reporting of potential abuse or neglect,[16] and their employees generally are covered by State laws for mandatory reporting.

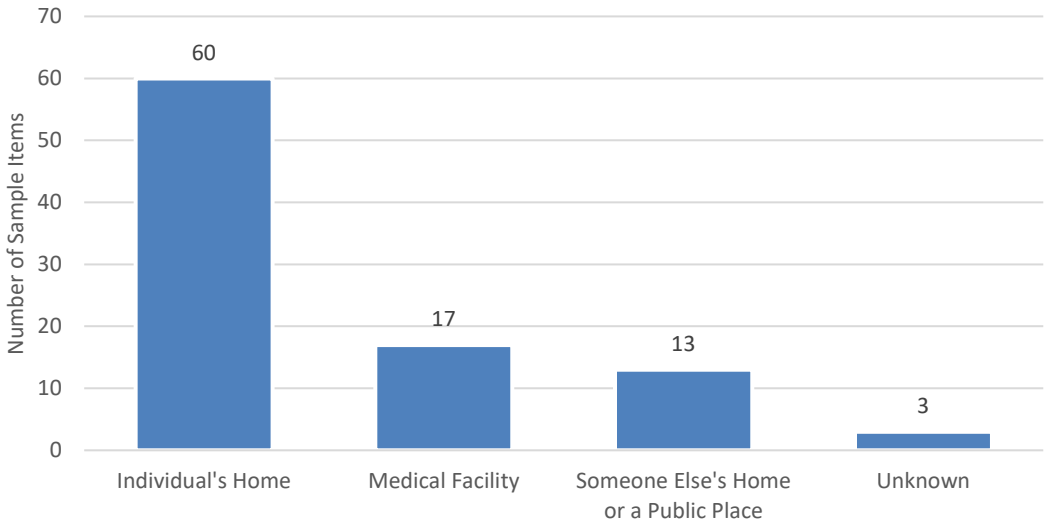
[15] Section 1150B of the Act does not cover other medical facilities such as hospitals, group homes, or assisted living facilities.

[16] For example, some States require group homes to report to the appropriate State agency any critical incident that involves emergency medical treatment of the group home residents.

The incidents of potential abuse or neglect associated with the Medicare claims we reviewed in our sample occurred in a variety of settings, most of which were not medical facilities. We determined that 17 of the 93 Medicare claims associated with incidents of potential abuse or neglect in our sample indicated that the abuse or neglect occurred at a medical facility. These medical facilities included nursing homes (12 claims), assisted living facilities (2 claims), group homes (2 claims), and a doctor's office (1 claim).[17] On the basis of our sample results, we estimated that 3,546 of the 30,258 Medicare claims in our sampling frame were associated with incidents of potential abuse or neglect that occurred at medical facilities.[18, 19]

In addition, we determined that, of the 93 Medicare claims associated with incidents of potential abuse or neglect in our sample, 60 were associated with incidents that occurred at the Medicare enrollees' homes and 13 occurred at other people's homes or public settings, such as parks and alleys. We were unable to determine where the remaining three incidents occurred. Figure 6 details the locations of the incidents for each of the 93 Medicare claims.

Figure 6: Locations of Incidents Associated With Sampled Medicare Claims for the Treatment of Potential Abuse or Neglect



[17] We classified assisted living facilities as medical facilities because they are generally regulated or licensed by the States and frequently employ certified nursing assistants, who are certified or licensed by the States.

[18] The 90-percent confidence interval for the number of Medicare claims in our sampling frame that were associated with incidents of potential abuse or neglect that occurred at medical facilities was 1,490 to 5,601.

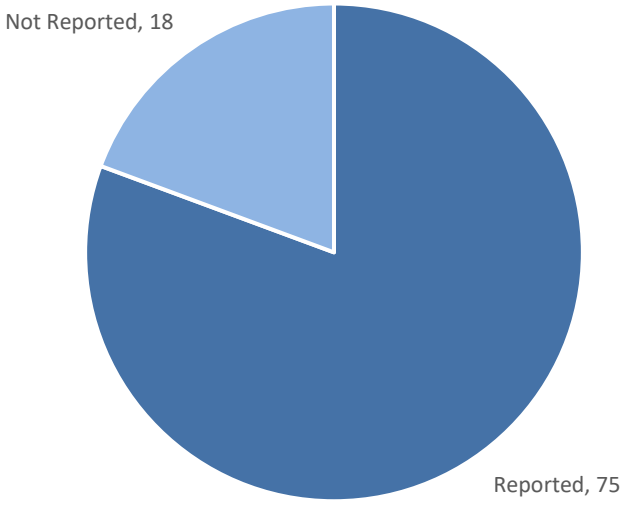
[19] The number of alleged perpetrators who were health care workers does not equal the number of potential incidents of abuse or neglect at medical facilities because some of the incidents at medical facilities involved alleged perpetrators who were not health care workers. For example, some of the alleged perpetrators at medical facilities were family members or other patients.

LAW ENFORCEMENT WAS NOT ALWAYS ALERTED TO INCIDENTS OF POTENTIAL ABUSE OR NEGLECT

Many, but not all, of the incidents of potential abuse or neglect were reported to law enforcement (Figure 7). Of the 93 Medicare claims associated with incidents of potential abuse or neglect in our sample, 18 were not reported to law enforcement by mandatory reporters even though all States require certain individuals to report suspected abuse, neglect, or exploitation of adults who are at a higher risk of suffering abuse, neglect, or exploitation. The remaining 75 incidents were reported to law enforcement.[20] On the basis of our sample results, we estimated that 7,298 of the 30,258 Medicare claims in our sampling frame were associated with incidents of potential abuse or neglect were not reported to law enforcement, including APS and local law enforcement as appropriate.

We contacted the health care provider associated with each of the 18 incidents of potential abuse or neglect that were not reported to law enforcement to determine the reasons they were not reported. Three of the providers did not respond to our inquiry. The remaining 15 providers gave a variety of explanations for not reporting the incidents to law enforcement. For example, one provider stated there was not enough evidence of abuse or neglect to report the incident. Another provider responded that the Medicare enrollee did not want the incident reported to law enforcement and the provider did not believe it was required to report the incident under State law.

Figure 7: Number of Medicare Claims Associated With Potential Abuse and Neglect in Our Sample That Were Reported to Law Enforcement



[20] These incidents were reported to law enforcement by a variety of sources, including the Medicare enrollees, their families, and health care providers.

MEDICARE CLAIMS DATA CAN BE USED TO HELP PROTECT MEDICARE ENROLLEES FROM ABUSE OR NEGLECT

CMS did not identify incidents of potential abuse or neglect during our audit period because it did not compile a list of diagnosis codes related to abuse or neglect and extract data consisting of Medicare claims containing at least one of those codes as we previously recommended. There is also no Federal requirement that CMS detect unreported incidents of potential abuse or neglect.

Based on the results of this audit, we maintain that Medicare data is a valuable resource that can be used to protect Medicare enrollees from abuse or neglect. This is especially important because the majority of individuals enrolled in Medicare are elderly or disabled. Accordingly, CMS's decision not to extract and analyze Medicare claims data with targeted diagnosis codes represents a missed opportunity to identify potential cases of abuse or neglect. In this regard, the lack of a data extract impeded the ability of CMS and public and patient safety organizations to pursue legal, administrative, and other appropriate remedies to ensure the safety, health, and rights of Medicare enrollees.

During the audit, we met with CMS officials to discuss the reasons for their nonconcurrence with our prior recommendations to extract Medicare claims data and to understand the obstacles associated with implementing the recommendations. In response to our prior recommendations, CMS said that although our review of claims data could provide helpful insight into past incidents involving potential abuse or neglect, the data may not be timely enough to address acute problems because providers generally have up to 1 calendar year from the date the service was provided to submit claims. CMS also noted that more than 80 percent of the incidents of potential abuse or neglect associated with the sampled Medicare claims in our prior audit "occurred in a home or public place, which do not fall under CMS's jurisdiction for Federal oversight." In addition to the concerns with timeliness and jurisdiction that CMS noted in its comments to our prior report, CMS indicated that providing Medicare claims data to all of the States may potentially violate the Health Insurance Portability and Accountability Act of 1996 and other privacy laws. Because protecting populations at a higher risk for abuse and neglect is a priority for CMS and the OIG, we developed revised recommendations that are both impactful and actionable based on our discussions with CMS.

The recommendations in this report reflect changes made to address CMS's concerns while maintaining a focus on leveraging Medicare claims data to identify unreported incidents of potential abuse or neglect. Our revised recommendations describe actions CMS, rather than the States, can take to use Medicare claims data and develop guidance for providers. Medicare claims data can be used to identify trends and patterns in claims containing diagnosis codes indicating potential abuse or neglect. CMS can use the results of claim analyses and reviews to develop new guidance to assist providers in reporting incidents and better protecting Medicare enrollees.

RECOMMENDATIONS

We recommend that the Centers for Medicare & Medicaid Services:

- conduct data analyses to identify trends and high-risk areas in Medicare claims containing diagnosis codes indicating potential abuse or neglect;

- provide the results of the analyses to QIOs and Medicare Program Integrity contractors so that they can conduct targeted claim reviews to identify patterns of unreported incidents of potential abuse or neglect and the reasons the incidents were unreported;

- based on the results of the targeted claim reviews, develop and share guidance and best practices with providers to assist providers in reporting incidents in compliance with State mandatory reporting laws; and

- consider the results of targeted claims reviews when assessing whether the existing requirements for reporting abuse or neglect of Medicare enrollees in provider CoPs should be strengthened.

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CMS concurred with our recommendations and described actions it plans to take to address most of them. Although CMS concurred with our first recommendation, it stated that it needed additional information to determine appropriate methodologies and whether it has the resources to conduct such data analyses. Regarding our second recommendation, CMS stated that it will consider whether providing the results of any data analyses to the QIOs for further action is feasible. CMS stated it will work toward an appropriate operational framework to implement this recommendation. Regarding our third recommendation, CMS stated that it will develop and share guidance to remind providers of their responsibility to report instances of potential abuse or neglect in accordance with their State licensure requirements. Regarding our fourth recommendation, CMS stated that it will evaluate all available evidence as it pertains to abuse and neglect when assessing the need for revisions to the existing CoPs.

We commend CMS for the actions it plans to take to address our recommendations. With respect to our first recommendation, we provided CMS with information on the methodology that we developed in our extensive work on identifying unreported incidents of potential abuse or neglect. Specifically, we provided CMS with a toolkit titled *A Resource Guide for Using Diagnosis Codes in Health Insurance Claims To Help Identify Unreported Abuse or Neglect* (A-01-19-00502).[21] This guide explains our approach when using claims data to identify incidents of potential abuse or neglect, and CMS can use this guide to determine the appropriate

[21] HHS-OIG, *A Resource Guide for Using Diagnosis Codes in Health Insurance Claims To Help Identify Unreported Abuse or Neglect* (A-01-19-00502) July 2019.

methodologies to conduct its own data analysis. Therefore, we continue to recommend that CMS conduct data analyses to identify trends and high-risk areas in Medicare claims containing diagnosis codes indicating potential abuse or neglect and provide the results of the analyses to the QIOs and Medicare Program Integrity contractors.

CMS's comments are included in their entirety as Appendix G.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 30,258 inpatient and outpatient claims totaling $138 million for services provided to Medicare enrollees from January 2019 through December 2020 to treat enrollees with at least 1 of 64 diagnosis codes related to abuse or neglect.[22] The 64 codes specifically indicate potential physical abuse, sexual abuse or rape, neglect or abandonment, or other maltreatment. We selected a stratified random sample of 100 Medicare claims and then reviewed the associated medical records to determine whether they contained evidence of potential abuse or neglect. If the medical record contained evidence of potential abuse or neglect, we then determined who may have perpetrated those incidents, where they occurred, and whether law enforcement was alerted.

We limited our review of internal controls to those applicable to our objectives. Specifically, we limited our review of internal controls to: (1) gaining an understanding of the laws and regulations concerning the reporting of potential abuse or neglect of Medicare enrollees, and (2) determining whether CMS had internal controls in place, such as data matches or extracts to identify incidents of potential abuse or neglect.

We performed our audit from December 2021 through July 2023.

METHODOLOGY

To accomplish our audit objectives, we:

- reviewed applicable Federal and State laws, regulations, and guidance;
- held discussions with CMS officials to understand the obstacles associated with implementing our prior audit recommendations to extract Medicare claims and make the data available to States;
- extracted from CMS's National Claims History file inpatient and outpatient claims for services provided from January 1, 2019, through December 31, 2020, and that contained at least 1 of the 64 targeted diagnosis codes;
- identified a sampling frame of 30,258 inpatient and outpatient claims that contained at least 1 of the 64 targeted diagnosis codes from January 1, 2019, through December 31, 2020;

[22] These 64 diagnosis codes were assigned by the physicians who treated the Medicare enrollees. We could not identify Medicare enrollees who were injured but not treated by a physician because there would have been no record of their treatment. Therefore, there is a risk that other Medicare enrollees who were potentially abused or neglected remain unidentified.

- selected a stratified random sample of 100 Medicare claims from the sampling frame of inpatient and outpatient claims;

- obtained the medical records from the health care providers associated with our sample of 100 Medicare claims;

- reviewed those medical records to determine:

    - if the record contained evidence of potential abuse or neglect,

    - the alleged perpetrator of the potential abuse or neglect,

    - the location of the potential abuse or neglect, and

    - if the incident of potential abuse or neglect was reported to law enforcement;

- identified the number of the total inpatient and outpatient claims that met each attribute described above;

- contacted law enforcement to confirm whether they were informed of incidents of potential abuse or neglect for our sample of 100 Medicare claims;

- reviewed the Medicare claims data to determine whether any Medicare enrollees died after an incident of potential abuse or neglect; and

- discussed the results of our audit with CMS officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Maine Implemented Our Prior Audit Recommendations and Generally Complied With Federal and State Requirements for Reporting and Monitoring Critical Incidents	A-01-20-00007	6/6/2022
Massachusetts Implemented Our Prior Audit Recommendations and Generally Complied With Federal and State Requirements for Reporting and Monitoring Critical Incidents	A-01-20-00003	4/25/2022
South Carolina Did Not Fully Comply With Requirements for Reporting and Monitoring Critical Events Involving Medicaid Beneficiaries With Developmental Disabilities	A-04-18-07078	4/1/2022
Arkansas Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	A-06-17-01003	12/22/2021
California Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	A-09-19-02004	9/22/2021
Louisiana Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	A-06-17-02005	5/5/2021
New York Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	A-02-17-01026	2/16/2021
Medicaid Data Can Be Used To Identify Instances of Potential Child Abuse or Neglect	A-01-19-00001	7/10/2020
Texas Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	A-06-17-04003	7/9/2020
Iowa Did Not Comply With Federal and State Requirements for Major Incidents Involving Medicaid Members With Developmental Disabilities	A-07-18-06081	3/27/2020
Pennsylvania Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	A-03-17-00202	1/17/2020
A Resource Guide for Using Diagnosis Codes in Health Insurance Claims To Help Identify Unreported Abuse or Neglect	A-01-19-00502	7/23/2019
CMS Could Use Medicare Data To Identify Instances of Potential Abuse or Neglect	A-01-17-00513	6/12/2019
Incidents of Potential Abuse and Neglect at Skilled Nursing Facilities Were Not Always Reported and Investigated	A-01-16-00509	6/12/2019

Report Title	Report Number	Date Issued
Alaska Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	A-09-17-02006	6/11/2019
Ensuring Beneficiary Health and Safety in Group Homes Through State Implementation of Comprehensive Compliance Oversight	Joint Report*	1/17/2018
A Few States Fell Short in Timely Investigation of the Most Serious Nursing Home Complaints: 2011-2015	OEI-01-16-00330	9/28/17
Early Alert: The Centers for Medicare & Medicaid Services Has Inadequate Procedures To Ensure That Incidents of Potential Abuse or Neglect at Skilled Nursing Facilities Are Identified and Reported in Accordance With Applicable Requirements	A-01-17-00504	8/24/17
Maine Did Not Comply With Federal and State Requirements for Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	A-01-16-00001	8/9/2017
Massachusetts Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries	A-01-14-00008	7/13/2016
Connecticut Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries	A-01-14-00002	5/25/2016
Review of Intermediate Care Facilities in New York With High Rates of Emergency Room Visits by Intellectually Disabled Medicaid Beneficiaries	A-02-14-01011	9/28/2015
Nursing Facilities' Compliance With Federal Regulations for Reporting Allegations of Abuse or Neglect	OEI-07-13-00010	8/15/2014
Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries	OEI-06-11-00370	2/27/2014
Criminal Convictions for Nurse Aides With Substantiated Findings of Abuse, Neglect, and Misappropriation	OEI-07-10-00422	10/5/2012
Unidentified and Unreported Federal Deficiencies in California's Complaint Surveys of Nursing Homes Participating in the Medicare and Medicaid Programs	A-09-09-00114	9/21/2011
Nursing Facilities' Employment of Individuals With Criminal Convictions	OEI-07-09-00110	3/1/2011
* This report was jointly prepared by HHS's OIG, Administration for Community Living, and Office for Civil Rights.		

APPENDIX C: FEDERAL LAWS AND REGULATIONS AND STATE PROGRAMS PROTECTING MEDICARE ENROLLEES FROM ABUSE AND NEGLECT

The Older Americans Act

The Older Americans Act, P.L. No. 89-73 (enacted July 14, 1965) was reauthorized as P.L. No. 114-144 (April 19, 2016) with a variety of objectives, including the protection of older persons from abuse, neglect, and exploitation. The Older Americans Act created the National Aging Network comprising the Administration on Aging at the Federal level, Units on Aging at the State level, and Area Agencies on Aging at the local level. This network provides funding, based primarily on the percentage of an area's population aged 60 years and older, for nutrition and supportive home and community-based services, disease prevention and health promotion services, elder rights programs, the National Family Caregiver Support Program, and the Native American Caregiver Support Program.

The Elder Justice Act

The EJA, enacted as part of the ACA on March 23, 2010, contains provisions that address certain public health and social services approaches to prevention, detection, and treatment of elder abuse primarily under HHS's authority and administration.[23] The EJA authorized several grant programs, such as a new State grant program for States' APS. It also established requirements for reporting crimes in long-term care facilities in section 1150B, "Reporting to Law Enforcement of Crimes Occurring in Federally Funded Long-Term Care Facilities."[24] In addition, the EJA created advisory bodies on elder abuse within HHS: the Elder Justice Coordinating Council and the Advisory Board on Elder Abuse, Neglect, and Exploitation.[25]

Delegation to CMS of the Enforcement of Section 1150B of the Social Security Act

Section 1150B of the Act states: "Each covered individual shall report to the Secretary and 1 or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime (as defined by the law of the applicable political subdivision) against any individual who is a resident of, or is receiving care from, the facility."[26] This section applies to a long-term care facility if it is determined that the facility received at least $10,000 in Federal funds during the preceding year. In June 2017, CMS began working with the HHS

[23] P.L. No. 111-148 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, P.L. No. 111-152 (Mar. 30, 2010). Subtitle H of the ACA of 2010 is also known as the EJA of 2009.

[24] Section 6703(b)(3) of the ACA.

[25] EJA §§ 2021 and 2022.

[26] A covered individual is defined in 42 U.S.C 1320b-25(a)(3) as "each individual who is an owner, operator, employee, manager, agent, or contractor of a long-term care facility that is the subject of determination . . .."

Office of the Secretary to receive the delegation of authority to enforce section 1150B but has not yet received the authority.

Conditions of Participation

CMS developed the CoPs that health care organizations must meet to participate in Medicare and Medicaid. These CoPs establish health and safety standards that are the foundation for improving quality and protecting the health and safety of enrollees. These CoPs are contained in the CFR under Title 42. The CoPs for long-term care facilities (nursing facilities and skilled nursing facilities) state that when there is an allegation of abuse or neglect, the facility must "report immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury." The long-term care facility must report the results of all investigations to the administrator and to other officials, including the State agency, in accordance with State law.[27]

State Survey Agencies

CMS is responsible for overseeing compliance with Medicare health and safety standards. CMS delegates a variety of tasks related to this oversight to the State Survey Agencies (the Act § 1864). One of these tasks is to conduct investigations and fact-finding surveys to determine how well health care providers comply with their applicable CoPs, including the reporting of potential abuse or neglect. When the State Survey Agencies or CMS Regional Office substantiates a finding of abuse, the State Survey Agency or Regional Office must report the substantiated finding to law enforcement and, if appropriate, to the State's MFCUs (*Medicare State Operations Manual,* chapter 5, § 5330). In fiscal year 2020, Federal funding of State Survey Agencies was an estimated $397 million.

Medicaid Fraud Control Units

Each State's MFCU investigates and prosecutes a variety of health care-related crimes, including patient abuse or neglect in health care facilities.[28] These health care facilities include skilled nursing facilities that receive Medicare reimbursement. MFCUs operate in all 50 States, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. MFCUs, which are usually a part of the State Attorney General's office, employ teams of investigators, attorneys, and auditors. OIG, in exercising oversight of MFCUs, annually recertifies each MFCU, assesses each MFCU's performance and compliance with Federal requirements, and administers a Federal grant award to fund a portion of each MFCU's operational costs.

[27] 42 CFR § 483.12, revised effective Nov. 28, 2016.

[28] The Act § 1903(q).

Adult Protective Services Programs

Each State has an APS program authorized by State law. State and local APS programs are considered among the first responders to reports of abuse, neglect, or exploitation of adults.[29] Upon receiving a report of abuse involving an elderly adult or an adult with disabilities, APS programs typically provide services, including an investigation of the allegation, evaluation of client risk and mental capacity, and ongoing monitoring of the delivery of services. APS programs also work closely with law enforcement if criminal abuse is suspected.

[29] Each State defines "adult" differently for APS purposes. For example, some States define an adult eligible for APS services as anyone aged 18 years or older, but other States define such an adult as anyone aged 60 years or older. Some States also require that the adults have been diagnosed with a physical or mental illness or a disability.

APPENDIX D: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

We obtained databases of Medicare claims data for all Medicare inpatient and outpatient claims that included at least 1 of 64 targeted diagnosis codes from January 1, 2019, through December 31, 2020. The 64 targeted codes indicated patients may have suffered physical abuse, sexual abuse or rape, neglect or abandonment, or other maltreatment (see Appendix F). The sampling frame consisted of 30,258 claims totaling $138,017,593.

SAMPLE UNIT

The sample unit was a Medicare claim.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample containing three strata. Stratum 1 contained inpatient claims in which the admitting diagnosis code was one of the targeted codes. Stratum 2 contained outpatient claims in which the principal diagnosis code was one of the targeted codes. Stratum 3 contained claims in which one of the targeted codes was included on the claim but was not the admitting or principal diagnosis code.

Table 1: Sample Design and Size

Stratum	Claim Type	Target Code Is Admitting or Principal	Frame Size (Claims)	Sample Size	Dollar Value of Frame Units
1	Inpatient	Yes	593	35	$7,054,245
2	Outpatient	Yes	9,952	35	4,118,027
3	Inpatient/Outpatient	No	19,713	30	126,845,321
Total			**30,258**	**100**	**$138,017,593**

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the OIG Office of Audit Services (OIG/OAS) statistical software.

METHOD FOR SELECTING SAMPLE ITEMS

We sorted the items in each stratum using a database field that is unique to each Medicare claim. We then consecutively numbered the sample units in the sampling frame for each stratum. After generating the random numbers for each of these strata, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the number of incidents of potential abuse or neglect and each of the other claim attributes listed in Appendix E. We calculated the point estimate and the corresponding two-sided 90-percent confidence interval for each of these estimates.

APPENDIX E: SAMPLE RESULTS AND ESTIMATES

CLAIM ATTRIBUTES FOR ESTIMATION

Attribute 1: Medical record contained evidence of potential abuse or neglect.

Attribute 2: Alleged perpetrator of abuse or neglect was a health care worker.

Attribute 3: Potential abuse or neglect occurred at a medical facility.

Attribute 4: Incident of potential abuse or neglect was not reported to law enforcement.

Table 2: Sample Results

Stratum	Frame Size (Claims)	Sample Size	Attribute 1	Attribute 2	Attribute 3	Attribute 4
1	593	35	35	9	9	3
2	9,952	35	30	3	5	7
3	19,713	30	28	2	3	8
Total	**30,258**	**100**	**93**	**14**	**17**	**18**

Table 3: Estimates by Attribute for the Sampling Frame
(Limits Calculated at the 90-percent Confidence Level)

Attribute	Statistical Estimates		
	Point Estimate	Lower Limit	Upper Limit
1	27,522	25,729	29,315
2	2,320	625	4,015
3	3,546	1,490	5,601
4	7,298	4,411	10,186

APPENDIX F: MEDICARE CLAIMS CONTAINING A DIAGNOSIS CODE INDICATING POTENTIAL ABUSE OR NEGLECT FROM JANUARY 2019 THROUGH DECEMBER 2020

Number	Diagnosis Code	Description	Total Number of Claims
1	T7401XA	Adult neglect or abandonment, confirmed, initial encounter	2,095
2	T7401XD	Adult neglect or abandonment, confirmed, subsequent encounter	233
3	T7402XA	Child neglect or abandonment, confirmed, initial encounter	5
4	T7402XD	Child neglect or abandonment, confirmed, subsequent encounter	1
5	T7411XA	Adult physical abuse, confirmed, initial encounter	3,755
6	T7411XD	Adult physical abuse, confirmed, subsequent encounter	331
7	T7412XA	Child physical abuse, confirmed, initial encounter	1
8	T7412XD	Child physical abuse, confirmed, subsequent encounter	0
9	T7421XA	Adult sexual abuse, confirmed, initial encounter	3,633
10	T7421XD	Adult sexual abuse, confirmed, subsequent encounter	658
11	T7422XA	Child sexual abuse, confirmed, initial encounter	2
12	T7422XD	Child sexual abuse, confirmed, subsequent encounter	0
13	T7431XA	Adult psychological abuse, confirmed, initial encounter	958
14	T7431XD	Adult psychological abuse, confirmed, subsequent encounter	329
15	T7432XA	Child psychological abuse, confirmed, initial encounter	0
16	T7432XD	Child psychological abuse, confirmed, subsequent encounter	0
17	T744XXA	Shaken infant syndrome, initial encounter	0
18	T744XXD	Shaken infant syndrome, subsequent encounter	1

Number	Diagnosis Code	Description	Total Number of Claims
19	T7451XA	Adult forced sexual exploitation, confirmed, initial encounter	18
20	T7451XD	Adult forced sexual exploitation, confirmed, subsequent encounter	4
21	T7452XA	Child forced sexual exploitation, confirmed, initial encounter	0
22	T7452XD	Child forced sexual exploitation, confirmed, subsequent encounter	0
23	T7461XA	Adult forced labor exploitation, confirmed, initial encounter	13
24	T7461XD	Adult forced labor exploitation, confirmed, subsequent encounter	0
25	T7462XA	Child forced labor exploitation, confirmed, initial encounter	0
26	T7462XD	Child forced labor exploitation, confirmed, subsequent encounter	0
27	T7491XA	Unspecified adult maltreatment, confirmed, initial encounter	2,649
28	T7491XD	Unspecified adult maltreatment, confirmed, subsequent encounter	879
29	T7492XA	Unspecified child maltreatment, confirmed, initial encounter	0
30	T7492XD	Unspecified child maltreatment, confirmed, subsequent encounter	3
31	T7601XA	Adult neglect or abandonment, suspected, initial encounter	4,170
32	T7601XD	Adult neglect or abandonment, suspected, subsequent encounter	114
33	T7602XA	Child neglect or abandonment, suspected, initial encounter	7
34	T7602XD	Child neglect or abandonment, suspected, subsequent encounter	1
35	T7611XA	Adult physical abuse, suspected, initial encounter	2,624
36	T7611XD	Adult physical abuse, suspected, subsequent encounter	116
37	T7612XA	Child physical abuse, suspected, initial encounter	1
38	T7612XD	Child physical abuse, suspected, subsequent encounter	0

Number	Diagnosis Code	Description	Total Number of Claims
39	T7621XA	Adult sexual abuse, suspected, initial encounter	3,435
40	T7621XD	Adult sexual abuse, suspected, subsequent encounter	94
41	T7622XA	Child sexual abuse, suspected, initial encounter	2
42	T7622XD	Child sexual abuse, suspected, subsequent encounter	0
43	T7631XA	Adult psychological abuse, suspected, initial encounter	352
44	T7631XD	Adult psychological abuse, suspected, subsequent encounter	29
45	T7632XA	Child psychological abuse, suspected, initial encounter	0
46	T7632XD	Child psychological abuse, suspected, subsequent encounter	0
47	T7651XA	Adult forced sexual exploitation, suspected, initial encounter	26
48	T7651XD	Adult forced sexual exploitation, suspected, subsequent encounter	3
49	T7652XA	Child forced sexual exploitation, suspected, initial encounter	0
50	T7652XD	Child forced sexual exploitation, suspected, subsequent encounter	0
51	T7661XA	Adult forced labor exploitation, suspected, initial encounter	5
52	T7661XD	Adult forced labor exploitation, suspected, subsequent encounter	0
53	T7662XA	Child forced labor exploitation, suspected, initial encounter	0
54	T7662XD	Child forced labor exploitation, suspected, subsequent encounter	0
55	T7691XA	Unspecified adult maltreatment, suspected, initial encounter	1,809
56	T7691XD	Unspecified adult maltreatment, suspected, subsequent encounter	103
57	T7692XA	Unspecified child maltreatment, suspected, initial encounter	1
58	T7692XD	Unspecified child maltreatment, suspected, subsequent encounter	0

Number	Diagnosis Code	Description	Total Number of Claims
59	Z0441	Encounter for examination and observation following alleged adult rape	1,332
60	Z0442	Encounter for examination and observation following alleged child rape	0
61	Z0471	Encounter for examination and observation following adult physical abuse	1,005
62	Z0472	Encounter for examination and observation following child physical abuse	1
63	Z0481	Encounter for examination and observation following forced sexual exploitation	39
64	Z0482	Encounter for examination and observation following forced labor exploitation	8
Claims With More Than One Diagnosis Code			(587)
Total			**30,258**

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

Date: September 21, 2023

To: Juliet T. Hodgkins
Principal Deputy Inspector General
Office of Inspector General

From: Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services

Subject: Office of Inspector General Draft Report: "CMS Can Do More To Leverage Medicare Claims Data To Identify Unreported Incidents of Potential Abuse or Neglect" (A-01-22-00501)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General (OIG) draft report on the reporting of incidents of potential abuse and neglect using Medicare claims data. Safety for all people who receive care and services in the Medicare and Medicaid programs is a top priority for CMS.

Abuse and neglect are never acceptable, and CMS requirements and guidance for Medicare and Medicaid certified providers reflect this sentiment by defining abuse and neglect and outlining steps for reporting, verifying, and responding to allegations. In addition, CMS requires providers to comply with all federal, state, and local laws related to the health and safety of the patient.[1][2][3] This would include state reporting requirements relating to suspicions of abuse and neglect of the patient by any individual.

OIG found that many incidents of potential abuse and neglect occur in healthcare facilities where CMS has no oversight jurisdiction. Over seventy-eight percent of the sample cases OIG identified in their audit as being associated with incidents of potential abuse or neglect occurred in a private home or public place, where CMS does not have oversight authority. In cases where individuals are living and being cared for at home, and are subsequently being brought to the hospital, it is the responsibility of the individual healthcare providers to comply with any applicable mandatory reporting laws for abuse and neglect in their state. Penalties such as possible jail time or fines would be applied by the state for a provider that fails to report as required under respective state laws.

[1] For example, the Hospice Conditions of Participation: Compliance with Federal, State, and local laws and regulations related to the health and safety of patients 42 C.F.R. § 418.116
[2] For example, the Hospital Conditions of Participation: Compliance with Federal, State and local laws 42 C.F.R. § 482.11
[3] For example, Requirements for States and Long Term Care Facilities: Compliance with Federal, State, and local laws and professional standards 42 C.F.R. § 483.70(b)

Monitoring the safety and quality of care received by Medicare and Medicaid providers and suppliers is an essential part of CMS's oversight efforts and requires coordinated efforts between the federal government and the states. CMS works in partnership with state survey agencies and national accrediting organizations (AOs) with CMS-approved programs to oversee providers' compliance with CMS requirements. Compliance reviews during surveys are accomplished through observations, interviews, and document/record reviews, including a review of allegations of abuse or neglect. State survey agencies are also authorized by CMS to conduct complaint investigations of providers, including those deemed by AOs, when allegations of non-compliance with CMS requirements are received. State survey agencies can conduct complaint investigation surveys at any time, and anyone can file a complaint, including but not limited Medicare and Medicaid beneficiaries, their family members, healthcare facilities, and anyone else who has reason to suspect abuse or neglect is taking place. Nursing home staff and other individuals who are required to report suspicions of crimes under 42 U.S.C. §1320b-24(a)(3), are required to report suspected abuse as specified under federal and state laws.[4] State survey agencies, as well as adult protective services, play an integral role in investigating complaints of abuse and neglect in a variety of health care settings and are responsible for reporting suspected crimes to local law enforcement, and if appropriate, to the Medicaid Fraud Control Units.

CMS also provides oversight validation surveys of states to determine whether state agencies are identifying deficiencies correctly, investigating compliance effectively, and meeting all other obligations. The CMS Locations conduct formal assessments annually of each state survey agency's performance relative to measures included in the State Performance Standards System (SPSS). The SPSS provides a framework to organize and measure important aspects of state survey activities. CMS also recently launched an initiative to evaluate the entire SPSS program to identify ways to improve state performance.[5] This is an ongoing, large-scale effort aimed at improving the efficiency and effectiveness of measuring and improving state performance.

CMS regularly reviews guidance and issues new guidance when needed, to support surveyors in identifying issues of non-compliance with CMS requirements. In March 2019, CMS made revisions to Appendix Q of the State Operations Manual to clarify what information is needed to identify immediate jeopardy-level cases across all Medicare and Medicaid healthcare provider and certified supplier types.[6] Immediate jeopardy is a situation in which a recipient of care has suffered or is likely to suffer serious injury, harm, impairment or death as a result of a provider's, supplier's, or laboratory's noncompliance with one or more health and safety requirements.[7] As part of this guidance, CMS has required a standardized notification process for surveyors to follow when immediate jeopardy is identified to ensure that providers are notified as soon as possible of an immediate jeopardy finding. This process has increased transparency, and improved timeliness and clarity of communication to providers. In addition to the guidance, CMS has developed an administrative tool that helps surveyors make sure they have the evidence needed to meet the criteria for an immediate jeopardy level determination of noncompliance.[8]

[4] Freedom from abuse, neglect, and exploitation 42 C.F.R. §483.12(c)
[5] [Revised] Fiscal Year 2023 State Performance Standards Systems (SPSS) Guidance
[6] CMS, Revisions to Appendix Q, Guidance on Immediate Jeopardy QSO-19-09-ALL.
[7] Survey, Certification, and Enforcement Procedures 42 CFR §488.1
[8] State Operations Manual, Appendix Q - Core Guidelines for Determining Immediate Jeopardy

CMS also updated guidance on requirements for abuse and neglect to further clarify compliance with abuse reporting, especially relating to facility-reported incidents.[9,10] Within that guidance, CMS provided examples of abuse that, because of the action itself, would be assigned to certain noncompliance severity levels. CMS also revised its interpretive guidance to surveyors to direct them to identify the type of abuse and alleged perpetrator type in their deficiency findings. Furthermore, CMS shared sample initial reporting forms and investigation reports that nursing homes may utilize.[11] For hospice providers, CMS has provided additional education on safeguards for patients in hospice care through a Medicare Learning Network Fact Sheet, and made revisions to Appendix M of the State Operations Manual to clarify procedures for surveyors reviewing hospice policies and procedures relating to instances of abuse or neglect and verifying that the hospice is reporting violations to the appropriate authorities in accordance with applicable state and Federal requirements.[12,13]

CMS remains diligent in our duties to monitor providers participating in Medicare and Medicaid across the country. CMS appreciates the ongoing work of the OIG in this area and will continue to work with them as we make improvements to our oversight efforts.

OIG's recommendations and CMS's responses are below.

OIG Recommendation 1

Conduct data analyses to identify trends and high-risk areas in Medicare claims containing diagnosis codes indicating potential abuse or neglect.

CMS Response 1

CMS concurs with this recommendation. CMS shares the OIG's goal of improving the reporting of cases of potential abuse and neglect. Additional information is needed to determine appropriate methodologies and whether CMS has the resources to conduct such analyses.

In addition, while such analyses may provide information on outliers to explore further, they could not identify whether individual cases of abuse or neglect are properly reported to the state and law enforcement.

Given the time-sensitive nature of instances of potential abuse and neglect, CMS will continue to prioritize its oversight of surveys and complaint work done by the state survey agencies.

[9] 42 C.F.R. § 483.12(b)
[10] CMS, Revised Long-Term Care Surveyor Guidance: Revisions to Surveyor Guidance for Phases 2 & 3, Arbitration Agreement Requirements, Investigating Complaints & Facility Reported Incidents, and the Psychosocial Outcome Severity Guide. June 29, 2022.
[11] CMS, Fact Sheet, Updated Guidance for Nursing Home Resident Health and Safety.
[12] CMS, Medicare Learning Network, Safeguards for Medicare Patients in Hospice Care Fact Sheet.
[13] CMS, Revisions to Hospice-Appendix M of the State Operations Manual and the Hospice Basic Surveyor Training, QSO-23-08-HOSPICE.

OIG Recommendation 2

Provide the results of the analyses to Quality Improvement Organizations (QIOs) and Medicare Program Integrity contractors so that they can conduct targeted claim reviews to identify patterns of unreported incidents of potential abuse or neglect and the reasons the incidents were unreported.

CMS Response 2

CMS concurs with this recommendation. CMS shares the OIG's goal of improving the reporting of cases of potential abuse and neglect. CMS will consider whether providing the results of any data analyses to the QIOs for further action and/or review is feasible and will work towards an appropriate operational framework to implement the recommendation.

Given the time-sensitive nature of instances of potential abuse and neglect, CMS will continue to prioritize its oversight of surveys and complaint work done by the state survey agencies.

OIG Recommendation 3

Based on the results of the targeted claim reviews, develop and share guidance and best practices with providers to assist providers in reporting incidents in compliance with State mandatory reporting laws.

CMS Response 3

CMS concurs with this recommendation. CMS regulations require Medicare- and Medicaid-certified facilities to comply with the mandatory reporting laws for abuse and neglect applicable to their state, including compliance with any timeliness requirements. CMS will develop and share guidance to remind providers of their responsibility to report instances of potential abuse or neglect, such as those described in the OIG's report, in accordance with their state licensure requirements.

OIG Recommendation 4

Consider the results of targeted claims reviews when assessing whether the existing requirements for reporting abuse or neglect of Medicare enrollees in provider Conditions of Participation (CoPs) should be strengthened.

CMS Response 4

CMS concurs with this recommendation. CMS will evaluate all available evidence as it pertains to abuse and neglect when assessing the need for revisions to the existing CoPs.