

EXHIBIT A

GREG WALDEN, OREGON  
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY  
RANKING MEMBER

ONE HUNDRED FIFTEENTH CONGRESS  
**Congress of the United States**  
**House of Representatives**  
COMMITTEE ON ENERGY AND COMMERCE  
2125 RAYBURN HOUSE OFFICE BUILDING  
WASHINGTON, DC 20515-6115  
Majority (202) 225-2927  
Minority (202) 225-3641

April 2, 2018

The Honorable Seema Verma  
Administrator  
Centers for Medicare and Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244

Dear Administrator Verma:

Pursuant to Rules X and XI of the U.S. House of Representatives, the Committee on Energy and Commerce (the committee) is continuing its oversight of Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs) participating in the Medicare and Medicaid programs. We appreciate the testimony that Principal Deputy Administrator for Operations Kimberly Brandt provided on this issue at the Subcommittee's October 24, 2017 hearing examining HHS' preparedness for and response to the 2017 hurricane season.

The committee has been closely following recent media reports describing horrific instances of abuse, neglect, and patient harm allegedly occurring at SNFs and NFs across the country, including at the Rehabilitation Center at Hollywood Hills where 14 residents died in the immediate aftermath of Hurricane Irma in Florida.<sup>1</sup> These reports raise serious questions about the degree to which the Centers for Medicare and Medicaid Services (CMS) is fulfilling its responsibility to ensure federal quality of care standards are being met, as well as its duty to protect vulnerable seniors from elder abuse and harm in facilities participating in the Medicare and Medicaid programs. The adequacy of the CMS' oversight of SNFs and NFs has also been called into question in recent reports issued by the Office of Inspector General at the U.S. Department of Health and Human Services (HHS OIG) and the U.S. Government Accountability Office (GAO).<sup>2</sup>

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<sup>1</sup> See, e.g., Blake Ellis and Melanie Hicken, *Sick, Dying and Raped in America's Nursing Homes*, CNN (Feb. 22, 2017), <http://www.cnn.com/interactive/2017/02/health/nursing-home-sex-abuse-investigation/>.

<sup>2</sup> U.S. Dep't of Health and Human Services, Office of Inspector General, *Top Management and Performance Challenges Facing HHS, #7 Ensuring Quality of Care and Safety for Vulnerable Populations* (last visited Mar. 29, 2018), available at <https://oig.hhs.gov/reports-and-publications/top-challenges/2016/challenge07.asp>; See, e.g., U.S. Dep't of Health and Human Services, Office of Inspector General, *Trends in Nursing Home Complaints* (last visited

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To assist the committee's efforts, we write today to request information about CMS' role overseeing SNFs and NFs, including the Rehabilitation Center at Hollywood Hills and other health care facilities where Dr. Jack Michel, managing member of the limited liability company that owns the Rehabilitation Center at Hollywood Hills, has an ownership interest. Further, the committee requests information and documents relating to CMS' oversight of all SNFs and NFs participating in the Medicare and Medicaid programs, especially relating to reports of sexual abuse and neglect.

### 1. Rehabilitation Center at Hollywood Hills

On October 20, 2017, the committee sent a bipartisan letter to Dr. Michel, requesting, among other things, information about the facility's emergency preparedness as well any past deficiencies identified by CMS or the Florida Agency for Health Care Administration (AHCA).<sup>3</sup> Tragically, according to the AHCA, the Rehabilitation Center at Hollywood Hills failed to follow adequate emergency management procedures after the facility's air conditioning system lost power during Hurricane Irma.<sup>4</sup> Despite increasingly excessive heat, staff at the facility did not take advantage of a fully functional hospital across the street and "overwhelmingly delayed calling 911" during a medical emergency.<sup>5</sup> Moreover, the facility had contractual agreements with an assisted living facility and transportation company for emergency evacuation purposes yet did not activate these services.<sup>6</sup> CMS therefore terminated this nursing home from the Medicare and Medicaid programs following an on-site inspection where surveyors found that the facility failed to meet Medicare's basic health and safety requirements.<sup>7</sup>

At the committee's October 24, 2017 hearing, Ms. Brandt testified that the heartbreaking event at this nursing home was the result of a "complete management failure," saying:

We make patient safety our number one priority for the residents of all of our Medicare and Medicaid facilities, and this was a complete management failure at

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Mar. 29, 2018), <https://oig.hhs.gov/oei/maps/nursing-home/>; U.S. Gov't Accountability Office, *Nursing Home Quality: CMS Should Continue to Improve Data and Oversight*, GAO-16-33 (Oct. 2015).

<sup>3</sup> Letter from Hon. Greg Walden, Chairman, H. Comm. on Energy & Commerce, et al., to Dr. Jack Michel, Owner, Rehabilitation Center at Hollywood Hills, LLC (Oct. 20, 2017), available at <https://energycommerce.house.gov/wp-content/uploads/2017/10/20171020HollywoodHills.pdf>.

<sup>4</sup> Florida Agency for Health Care Administration, *Press Release: AHCA Suspends the License of the Rehabilitation Center of Hollywood Hills* (Sept. 20, 2017); Paul McMahon, et al., *Ninth nursing home patient dies; Gov. Scott details contact with state*, SUN SENTINEL (Sept. 19, 2018), available at <http://www.sun-sentinel.com/news/hollywood-nursing-home-hurricane-deaths/fl-reg-nursing-home-ninth-death-20170919-story.html>.

<sup>5</sup> AHCA Press Release, *ACHA Suspends the License of the Rehabilitation Center of Hollywood Hills*, (Sept. 20, 2017); U.S. Dep't of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), *Survey of the Rehabilitation Center at Hollywood Hills, LLC*, at 2 (Sept. 22, 2017); *State of Florida, Agency for Health Care Administration vs. Rehabilitation Center at Hollywood Hills, LLC*, Emergency Suspension Order (Sept. 20, 2017).

<sup>6</sup> U.S. Dep't of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), *Survey of the Rehabilitation Center at Hollywood Hills, LLC* (Sept. 22, 2017).

<sup>7</sup> U.S. Dep't of Health and Human Services, Centers for Medicare and Medicaid Services, *Notice to Public of Rehabilitation Center at Hollywood Hills, Termination Notice* (Oct. 11, 2017), available at <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Termination-Notice-Florida-NH-Rehabilitation-Center-at-Hollywood-Hills-LLC.pdf>.

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Hollywood Hills, which is why they were terminated. They did not meet our conditions of participation for keeping the temperature at a reasonable level. They did not provide adequate care to the patients. As you mentioned, there was a hospital right across the street... So they had several levels of what we call immediate jeopardy for patients, which is why they were terminated.<sup>8</sup>

The Rehabilitation Center at Hollywood Hills disagrees with the AHCA's assessment of the situation and is challenging the AHCA's decision to revoke the nursing home's license.<sup>9</sup> In its filing opposing the AHCA's revocation of its license, the nursing home asserts that "it acted with the utmost prudence at all times during and after the hurricane," and contrary to the allegation of the state agency, it was not an "isolated incident" as other nursing homes experienced similar issues.<sup>10</sup> The Rehabilitation Center at Hollywood Hills argues that "the deaths of [its] residents [were] not due to any negligence or sub-standard of care, but due to the large-scale, natural disaster endured by the frail, elderly residents."<sup>11</sup> However, in a January 2015 court filing pertaining to an unrelated case, attorneys for Dr. Michel averred that if the facility's air conditioning system failed, it would be a "catastrophe" and "the facility would have to be shut down and the patients evacuated."<sup>12</sup>

This is not the first time Dr. Michel and a facility he has an ownership interest in has been scrutinized by the federal government. In 2006, Dr. Michel, Larkin Community Hospital (Larkin), and others entered into a settlement agreement with DOJ to resolve a civil case in which the government alleged Dr. Michel and his associates paid kickbacks and performed medically unnecessary treatments on elderly beneficiaries to generate Medicare and Medicaid payments.<sup>13</sup> According to DOJ's complaint, Dr. Michel initiated the scheme during a meeting with an associate of the then-owner of a nearby hospital, Larkin, by proposing "ask your boss if he would pay \$1 million to make \$5 million."<sup>14</sup> Thereafter, Dr. Michel and his associates allegedly entered into a scheme to engage in seven different types of kickback arrangements.<sup>15</sup>

One part of the scheme allegedly involved Larkin paying Dr. Michel approximately \$70,000 in kickbacks per month for patient referrals.<sup>16</sup> After later acquiring an ownership interest

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<sup>8</sup> U.S. House of Representatives, Comm. on Energy & Commerce, *Examining HHS's Public Health Preparedness for and Response to the 2017 Hurricane Season* (Oct. 24, 2017), <https://energycommerce.house.gov/hearings/examining-hhss-public-health-preparedness-response-2017-hurricane-season/>.

<sup>9</sup> *State of Florida, Petitioner, v. Rehabilitation Center at Hollywood Hills, LLC*, Respondent, Hollywood Hill's Response to AHCA's Motion to Quash and Motion for Protective Order, DOAH Case No. 17-005769 (Nov. 20, 2017), available at [https://www.doah.state.fl.us/DocDoc/2017/005769/17005769\\_237\\_11202017\\_09381192\\_e.pdf](https://www.doah.state.fl.us/DocDoc/2017/005769/17005769_237_11202017_09381192_e.pdf).

<sup>10</sup> *Id.*

<sup>11</sup> *Id.*

<sup>12</sup> Megan O'Matz, *Nursing home owner once argued A/C failure would spur evacuations. But when Irma hit, they stayed put*, SUN SENTINEL (Dec. 14, 2017), <http://www.sun-sentinel.com/news/hollywood-nursing-home-hurricane-deaths/fl-reg-nursing-home-ac-evacuate-20171213-story.html>.

<sup>13</sup> U.S. Dep't of Justice, Press Release, *Miami Hospital Pays \$15.4 Million to Resolve Fraud Case for Kickbacks & Medically Unnecessary Treatments* (Nov. 30, 2006), available at [https://www.justice.gov/archive/opa/pr/2006/November/06\\_civ\\_803.html](https://www.justice.gov/archive/opa/pr/2006/November/06_civ_803.html).

<sup>14</sup> *United States v. Jack Jacob Michel, et al.*, Complaint of the United States, No-04-21579-CIV-JORDAN/TORRES, at 31 (Filed Jun. 29, 2004) (S.D. Fla.).

<sup>15</sup> *Id.* at 30-36.

<sup>16</sup> *Id.* at 32.

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in Larkin, Dr. Michel arranged a scheme to have patients sent there because the facility lacked patients.<sup>17</sup> During that arrangement, elderly patients received medical treatments and extended hospitalizations that were not necessary.<sup>18</sup> A survey conducted by the AHCA showed that at least 50 percent “of the services rendered to the patients in that study were medically unnecessary.”<sup>19</sup> Dr. Michel and the parties eventually settled with DOJ for \$15.4 million without an admission of guilt.<sup>20</sup>

Contemporaneously with the settlement agreement, Larkin and Dr. Michel entered into a five-year Corporate Integrity Agreement (CIA) with HHS OIG in 2006.<sup>21</sup> Despite the CIA, media reports indicate that from approximately 2002 to 2016 at least one then-employee and physicians at Larkin were allegedly involved in the largest single criminal health care fraud case ever brought against individuals by DOJ.<sup>22</sup> More recently, state regulators have raised concerns about patient safety at another facility owned by Dr. Michel.<sup>23</sup> In December 2016, the AHCA found 30 violations at Floridian Gardens Assisted Living Facility, including “sexual assault of patients, low staffing, and ignoring patients.”<sup>24</sup> As a result, the facility was banned from accepting new patients for several months.<sup>25</sup> In September, the AHCA took additional steps to close Floridian Gardens.<sup>26</sup>

Additionally, Dr. Michel has continuously received substantial amounts of taxpayer money outside of the Medicare and Medicaid programs despite serious questions being raised about his facilities. According to media reports, Larkin, the hospital owned by Dr. Michel, has

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<sup>17</sup> *Id.* at 37.

<sup>18</sup> *Id.*

<sup>19</sup> *Id.*

<sup>20</sup> U.S. Dep’t of Justice, Press Release, *Miami Hospital Pays \$15.4 Million to Resolve Fraud Case for Kickbacks & Medically Unnecessary Treatments* (Nov. 30, 2006), available at [https://www.justice.gov/archive/opa/pr/2006/November/06\\_civ\\_803.html](https://www.justice.gov/archive/opa/pr/2006/November/06_civ_803.html); See also *United States v. Philip Esformes*, Government’s Motion for Pre-Trial Detention and Supporting Memorandum, Case No. 16-20549, at Attachment B, Page 6 (Filed Jul. 22, 2016) (S.D. Fla.) (Attachment B includes Settlement Agreement Binder from *United States v. Michel* (“Civil Action”), No-04-21579-CIV-JORDAN/TORRES (S.D. Fla.)).

<sup>21</sup> U.S. Dep’t of Health and Human Services, Office of Inspector General, *Integrity Agreement Between the Office of Inspector General of the Dep’t of Health and Human Services and Jack J. Michel, M.D.* (Nov. 17, 2006); U.S. Dep’t of Health and Human Services, Office of Inspector General, *Integrity Agreement Between the Office of Inspector General of the Dep’t of Health and Human Services and Larkin Community Hospital* (Nov. 13, 2006).

<sup>22</sup> Jay Weaver, *Bribes to low-paid state worker key to \$1 billion Miami Medicare fraud case, prosecutors say*, MIAMI HERALD (Jul. 29, 2017), available at <http://www.miamiherald.com/news/local/article164232522.html>; See also U.S. Dep’t of Justice, Press Release, *Three Individuals Charged in \$1 Billion Medicare Fraud and Money Laundering Scheme* (Jul. 22, 2016), available at <https://www.justice.gov/opa/pr/three-individuals-charged-1-billion-medicare-fraud-and-money-laundering-scheme>.

<sup>23</sup> Melanie Payne & Arek Sarkissian, *Nursing Home Deaths: Owner’s Other Facility Faced State Ban on New Patients*, USA TODAY NETWORK FLORIDA, (Sept. 15, 2017), available at <https://www.usatoday.com/story/news/nation-now/2017/09/15/nursing-home-deaths-owners-other-facility-faced-state-ban-new-patients/672340001/>.

<sup>24</sup> *Id.*

<sup>25</sup> *Id.*

<sup>26</sup> See Florida Agency for Health Care Administration, *Press Release: AHCA Takes Additional Action to Close Larkin-Owned ALF* (Sept. 28, 2017), [https://www.abca.myflorida.com/Executive/Communications/Press\\_Releases/pdf/Larkin-OwnedALFPR.pdf](https://www.abca.myflorida.com/Executive/Communications/Press_Releases/pdf/Larkin-OwnedALFPR.pdf).

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received \$46.6 million to treat federal inmates since 2002.<sup>27</sup> Larkin has also received \$48 million to treat state inmates.<sup>28</sup>

## 2. National Nursing Home Resident Abuse and Neglect

Over the past year, there have been several deeply troubling press articles describing instances of nursing home residents being abused and neglected and, in some instances, the nursing homes subsequently failing to adequately detect and investigate the abuse and neglect.<sup>29</sup> These articles include horrific examples of elderly individuals being beaten by fellow residents and staff,<sup>30</sup> being sexually assaulted by fellow residents and staff,<sup>31</sup> and being neglected by staff during medical emergencies.<sup>32</sup> The articles also detail how, in some instances, a facility had a history of violations and sanctions before being shut down while others did not incur any financial penalty even after being cited for not protecting residents after a case of sexual abuse was substantiated.<sup>33</sup> According to one report, even once a facility is shut down due to instances of abuse and neglect, the residents are not necessarily moved to a safer location.<sup>34</sup>

Unfortunately, these do not appear to be isolated incidents. Analysis conducted by one news outlet found that between 2013 and 2016, the federal government cited more than 1,000 nursing homes for either mishandling cases related to, or failing to protect residents against, rape, sexual abuse or sexual assault, with nearly 100 facilities incurring multiple citations.<sup>35</sup> The timeliness of nursing home complaint investigations also raises concerns as well. A September 2017 data brief issued by the HHS OIG found that in 2015, 764 immediate jeopardy nursing home complaints were not investigated by state agencies within two working days, as required by CMS, with 473 complaints not being investigated within 15 days.<sup>36</sup> Immediate jeopardy is described by CMS as being instances where “the facility’s noncompliance with one or more

<sup>27</sup> Arek Sarkissian, *Hurricane Irma: Hospital Linked to Nursing-Home Deaths was Paid \$48M to Care for Florida Prisoners*, USA TODAY NETWORK FLORIDA, (Sept. 26, 2017), available at <https://www.usatoday.com/story/news/nation-now/2017/09/26/hurricane-irma-hospital-owned-doctor-whose-nursing-home-had-11-residents-die-paid-48-m-care-florida/705869001/>.

<sup>28</sup> *Id.*

<sup>29</sup> Ellis and Hicken, *supra* note 1.

<sup>30</sup> See, e.g., Elizabeth Cohen, *Retirement home shut down months after attack on 86-year-old*, CNN (Dec. 28, 2017), <http://www.cnn.com/2017/12/28/health/retirement-home-neglect-florida/index.html>; Shaddi Abusaid, *Warrant: Nursing home employee admitted beating elderly patient*, MARIETTA DAILY JOURNAL (Aug. 21, 2017), [http://www.mdjonline.com/news/warrant-nursing-home-employee-admitted-beating-elderly-patient/article\\_177c79a0-86e2-11e7-a627-474e6ed45dcd.html](http://www.mdjonline.com/news/warrant-nursing-home-employee-admitted-beating-elderly-patient/article_177c79a0-86e2-11e7-a627-474e6ed45dcd.html).

<sup>31</sup> See, e.g., Ellis and Hicken, *supra* note 29; Blythe Bernhard, *Troubled Florissant nursing home loses Medicare funding after resident bleeds to death*, ST. LOUIS POST-DISPATCH (Dec. 12, 2017), [http://www.stltoday.com/lifestyles/health-med-fit/health/troubled-florissant-nursing-home-loses-medicare-funding-after-resident-bleeds/article\\_7da08e12-d698-5c01-a46b-950b652a0101.html](http://www.stltoday.com/lifestyles/health-med-fit/health/troubled-florissant-nursing-home-loses-medicare-funding-after-resident-bleeds/article_7da08e12-d698-5c01-a46b-950b652a0101.html).

<sup>32</sup> Avi Selk, *A dying vet needed CPR. Hidden video shows his nurse laughing instead*, WASH. POST (Nov. 18, 2017), [https://www.washingtonpost.com/news/to-your-health/wp/2017/11/18/a-dying-vet-needed-cpr-hidden-video-shows-his-nurse-laughing-instead/?utm\\_term=.b932366afb3a](https://www.washingtonpost.com/news/to-your-health/wp/2017/11/18/a-dying-vet-needed-cpr-hidden-video-shows-his-nurse-laughing-instead/?utm_term=.b932366afb3a).

<sup>33</sup> See Cohen, *supra* note 30.

<sup>34</sup> Marjie Lundstrom and Phillip Reese, *Where do patients go when a troubled nursing home closes? Often, nowhere better*, The Sacramento Bee (Oct. 23, 2017), <http://www.sacbee.com/news/local/article180324246.html>.

<sup>35</sup> Ellis and Hicken, *supra* note 1.

<sup>36</sup> U.S. Dep’t of Health and Human Services, Office of Inspector General, *A Few States Fell Short in Timely Investigation of the Most Serious Nursing Home Complaints: 2011-2015* (OEI-01-16-00330) (Sept. 2017), <https://oig.hhs.gov/oei/reports/oei-01-16-00330.pdf>.

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requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.”<sup>37</sup> The OIG also found that 4,743 high priority nursing home complaints were not investigated in 2015 within the required 10 working day period.<sup>38</sup>

For over a decade, HHS OIG has identified improving care for vulnerable populations, including the care provided to individuals who receive nursing home care, as a top management challenge for HHS and has continuously expressed concerns about residents being at risk of abuse and neglect.<sup>39</sup> In the HHS OIG’s 2017 report on “Top Management Challenges Facing HHS,” HHS OIG wrote:

Nursing facilities continue to experience problems ensuring quality of care and safety for people residing in them. OIG identified instances of substandard care causing preventable adverse events, finding that an estimated 22 percent of Medicare beneficiaries had experienced an adverse event during their nursing home stay. OIG has also raised concerns about the potentially inappropriate use of powerful antipsychotic drugs for nursing home residents. In addition, CMS has often failed to require nursing facilities to correct all deficiencies identified during the survey process, and OIG has identified nursing home staff who do not meet relevant licensure requirements.

Further, OIG continues to raise concerns about nursing home residents being at risk of abuse and neglect. In some instances, nursing home care is so substandard that providers may have liability under the False Claims Act. OIG recently alerted CMS to instances of nursing facilities’ failures to identify and report abuse and neglect as required and deficiencies in procedures for enforcing these requirements. OIG alerted CMS about 134 Medicare beneficiaries treated in 2015 and 2016 for injuries that may have been caused by abuse or neglect while the beneficiary was receiving care in a nursing home.<sup>40</sup>

The early alert issued by HHS OIG last August—and referenced in the aforementioned quote from HHS OIG’s report on HHS’ top management challenges—indicated that HHS OIG

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<sup>37</sup> U.S. Dep’t of Health and Human Services, Centers for Medicare & Medicaid Services, *Nursing Home Enforcement* (last accessed Mar. 29, 2018), <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationEnforcement/Nursing-Home-Enforcement.html>.

<sup>38</sup> Office of Inspector General, *supra* note 36.

<sup>39</sup> U.S. Dep’t of Health and Human Services, Office of Inspector General, *Top Management and Performance Challenges Facing HHS 2017, #4 Improving Care for Vulnerable Populations* (last accessed Mar. 29, 2018), <https://oig.hhs.gov/reports-and-publications/top-challenges/2017/2017-tmc.pdf>; U.S. Dep’t of Health and Human Services, Office of Inspector General, *Top Management and Performance Challenges Facing HHS 2016, #7 Ensuring Quality of Care and Safety for Vulnerable Populations* (last accessed Mar. 29, 2018), [https://oig.hhs.gov/reports-and-publications/top-challenges/2016/TMC\\_2016\\_508.pdf](https://oig.hhs.gov/reports-and-publications/top-challenges/2016/TMC_2016_508.pdf); U.S. Dep’t of Health and Human Services, Office of Inspector General, *OIG’s FY 2015 Top Management and Performance Challenges Facing the Department of Health and Human Services, Management Challenge 6: Ensuring Quality in Nursing Home, Hospice, and Home- and Community-Based Care* (last accessed Mar. 29, 2018), <https://oig.hhs.gov/reports-and-publications/top-challenges/2015/2015-tmc.pdf>.

<sup>40</sup> U.S. Dep’t of Health and Human Services, Office of Inspector General, *Top Management and Performance Challenges Facing HHS 2017, #4 Improving Care for Vulnerable Populations* (last accessed Mar. 29, 2018), <https://oig.hhs.gov/reports-and-publications/top-challenges/2017/2017-tmc.pdf>.

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identified 134 Medicare beneficiaries who were treated in 2015 and 2016 for injuries that may have been caused by abuse or neglect while the individual was receiving care at a SNF.<sup>41</sup> In its alert, HHS OIG raised concerns that CMS has inadequate procedures to ensure that incidents of potential abuse or neglect at SNFs are identified and reported in accordance with applicable requirements.<sup>42</sup> Under Section 1150B of the Social Security Act, covered individuals in federally funded SNFs and NFs are required to immediately report any reasonable suspicion of a crime committed against a resident of that facility.<sup>43</sup> The law imposes various penalties, including civil monetary penalties of up to \$300,000 and possible exclusion from participation in Federal health care programs, for failure to report possible crimes against SNF and NF residents.<sup>44</sup> According to HHS OIG, CMS has not, however, taken any enforcement actions using section 1150B of the Social Security Act or used the penalties it contains despite its effective date of March 23, 2011.<sup>45</sup> CMS officials told HHS OIG that CMS has not taken any enforcement actions using section 1150B “because the HHS Office of the Secretary has not delegated the enforcement of section 1150B to CMS.”<sup>46</sup> CMS further indicated that it had commenced working with the HHS Office of the Secretary in June 2017 to obtain the delegated enforcement authority.<sup>47</sup> During a September 2017 call with committee staff, CMS staff indicated CMS was working as quickly as possible to delegate the authority.<sup>48</sup>

Given the committee’s examination of CMS’ oversight of SNFs and NFs, and the Rehabilitation Center at Hollywood Hills more specifically in light of the recent tragedy and the serious nature of the allegations against Dr. Michel, we request that CMS provide committee staff with a briefing on these issues no later than April 16, 2018. Additionally, please provide the following document and information as soon as possible, but no later than April 23, 2018:

1. All documents and information relating to Dr. Michel and any facility participating in the Medicare and Medicaid programs that is owned, operated, or controlled by Dr. Michel;
2. A copy of any review or report drafted by CMS relating to Department of Justice allegations that Dr. Michel arranged for medically unnecessary treatments for elderly patients to generate Medicare and Medicaid payments;
3. All documents and information relating to any audits CMS or any of its contractors have done of the Medicare cost reports submitted by Larkin Community Hospital;

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<sup>41</sup> U.S. Dep’t of Health and Human Services, Office of Inspector General, *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)* (Aug. 24, 2017), <https://oig.hhs.gov/oas/reports/region1/11700504.pdf>.

<sup>42</sup> *Id.*

<sup>43</sup> *Id.*

<sup>44</sup> *Id.*

<sup>45</sup> *Id.*

<sup>46</sup> *Id.*

<sup>47</sup> *Id.*

<sup>48</sup> U.S. House of Representatives, Comm. on Energy and Commerce, Subcomm. On Oversight and Investigations, 115th Cong. Committee Phone Briefing with U.S. Dep’t of Health and Human Services, Centers for Medicare and Medicaid Services (Sept. 15, 2017).



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4. All documents and information CMS has about complaints received by state survey agencies regarding or relating to incidents at long-term care facilities participating in the Medicare and Medicaid programs resulting from Hurricanes Harvey, Irma, and Maria, including but not limited to, actions CMS or state survey agencies took in response to these complaints;
5. All documents and information relating to federal grants received by Larkin Community Hospital to treat federal inmates;
6. All documents and information referring or relating to the nursing home survey and certification process since January 1, 2010, including, but not limited to, all documents and information referring or relating to the action(s) taken to ensure any deficiencies were corrected;
7. All documents and information referring or relating to nursing home complaint investigations undertaken since January 1, 2010, including, but not limited to, all documents and information referring or relating to the action(s) taken in response to any substantiated complaint(s);
8. All documents and information CMS has about complaints received by state survey agencies regarding or relating to incidents at long-term care facilities participating in the Medicare and Medicaid programs that CMS has selected as a Special Focus Facility (SFF), including but not limited to, actions CMS or state survey agencies took in response to these complaints;
9. Information about how CMS ensures nursing home staff satisfy all relevant licensure requirements and what, if anything, CMS has done to improve compliance with licensure requirements; and
10. Information about whether HHS has finished delegating the enforcement of Section 1150B of the Social Security Act to CMS, and, if so, whether CMS has taken any enforcement actions regarding Section 1150B.

An attachment to this letter provides additional information about complying with the committee's request. If you have any questions about this letter, please contact Natalie Turner, Lamar Echols, or Christopher Santini of the majority committee staff at 202-225-2927. Thank you for your prompt attention to this matter.

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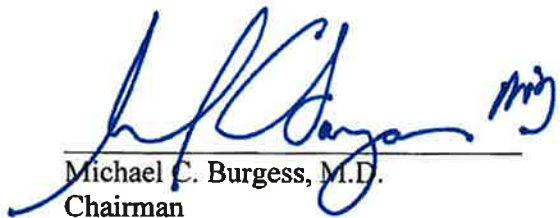
Sincerely,



Greg Walden  
Chairman



Gregg Harper  
Chairman  
Subcommittee on Oversight  
and Investigations



Michael C. Burgess, M.D.  
Chairman  
Subcommittee on Health



Gus M. Bilirakis  
Member of Congress

cc: The Honorable Frank Pallone, Jr., Ranking Member

The Honorable Gene Green, Ranking Member  
Subcommittee on Health

The Honorable Diana DeGette, Ranking Member  
Subcommittee on Oversight and Investigations

Attachment