Federal Enforcement Initiatives in Long Term Care

Resident-Centered Settlements

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Clear Evidence of Improvement

- Anti-psychotics overuse – 33% to 16%
- Antidepressant use – 12.6% to 24.9%
- Inappropriate restraints – 38% to <15%
- Urinary Catheters – 30% decrease
- Hearing aids – 30% increase
Surveys are too predictable
Several states rarely cite for substandard care
= inadequate survey and enforcement
Preventable suffering – pressure ulcers, malnutrition, dehydration
Continued physical & verbal abuse, neglect and misappropriation of property
Continuous Quality Improvement Efforts

- Eliminate Some “Opportunities to Correct”
- For “Special Focus Facilities” – More Frequent Inspections
- Staggered Survey Times
- CMPs per Deficiency – SOM Changes
- “Poor Performing” Chains – Corporate Liability
Stronger Federal Oversight

- Additional Training
- Enhanced Federal (RO) Review of Survey Results
- Enforce Strong Selection and Revisit Policies
- Sanction States for Inadequate Survey Performance
Additional Initiatives

- Established under HIPAA in 1996
  - Health Care Fraud and Abuse Control Program (HCFAC)
  - Coordination of federal, state, and local law enforcement healthcare fraud and abuse enforcement activities into a collaborative effort
  - HHS OIG, USAOs, FIB, MFCUs
- New Health Fraud Crimes
  - Health Care Fraud
  - Health Care False Statements
Additional Initiatives

- HCFAC “Successes”
- Enforcement and oversight of fraud and abuse in SNFs, particularly issues relating to quality of care
- Vencor settlement
- First HHS/OIG exclusions of an owner for quality of care violations
DOJ Training Initiatives

- October 1999 – Nursing Home Abuse and Neglect Prevention Conference
- June 2000 – Nursing Home Abuse and Neglect State Working Group Meeting
  - Outreach, referral, education, advocacy
- October 2000 – Elder Victimization Symposium (co-sponsored with DHHS)
- January 2002 – OIG Cooperative Symposium

Publications

- Medical Forensic Aspects of Elder Abuse and Neglect
- Promising Practices to Prevent Elder Victimization
New Initiatives

**DOJ Nursing Home Initiative & Elder Justice efforts**

- Stepped up Civil & Criminal Enforcement in Cases Impacting Older Americans
  - No Federal elder abuse and neglect statute
  - Pending Federal Legislation
    - S 2240 – Seniors Safety Act of 2002
  - “Failure of Care” prosecutions where systemic wrongdoing results in serious harm or death and false statements or financial fraud to the government
    - Services not rendered at all or,
    - Services so grossly deficient as to be essentially no care at all
Additional Initiatives

- **DOJ Nursing Home Initiative & Elder Justice efforts**
  - Creation of State work groups to coordinate enforcement efforts
  - $1.7 Billion in recoveries reports from 10/99 – 1/01
  - Consumer fraud prosecutions
  - Civil rights enforcement – CRIPA
    - Government sponsored public facilities only
      - E.G., County nursing homes
MFCUs

- Activity and approach varies from state to state
- Enforcement authority extends beyond nursing homes
- Target corporations as well as individuals, looking for “corporate-driven neglect”
- Use survey reports to target enforcement activity
- Virginia “Operation Sentinel” = very aggressive
Virginia Patient Abuse and Neglect Squad

- Created in 1999
- Funded primarily by federal grant
- 168 complaints
  - Corporate neglect
  - Assaults against the elderly
- 60 investigations total; 11 current
- 6 convictions
- April 30-May 1, 2002 Elder Rights: Coming of Age
Continued Congressional Oversight

- **July 2001** – US House of Representatives
  - **Committee on Government Reform**
  - *Abuse of Residents is a Major Problem in U.S. Nursing Homes*

- **March 2002** – Senate Special Committee on Aging Hearing – *Safeguarding Our Seniors: Protecting the Elderly from Physical and Sexual Abuse in Nursing Homes*

- **GAO-02-312** – *Nursing Homes: More Can Be Done to Protect Residents From Abuse (March 2002)*

- **Patient Abuse Prevention Act**
  - **National Registry**
  - **National Criminal Background Checks**
The Interface

- Operations
- Quality
- Compliance
- Risk Management
NURSING HOMES IN A NUTSHELL

Characteristics of the Practice Setting
- Intensive Care, Intensive Scrutiny
- The three Rs of Long Term Care
  - REIMBURSEMENT
  - RECRUITMENT/RETENTION
  - REGULATION
Management in a Highly Regulated Environment

- Who is the Customer?
- Stakeholder analysis in Long Term Care
- Defining the “Standard of Care”
COMPUTERS ENCOURAGE THE COLLECTION OF INFORMATION

-- NOT THE DECISIVE USE OF IT!
USES of the MDS Data

Data-Driven Survey Process - QIs
Research & Policy Initiatives
Reimbursement
Program Integrity & Enforcement
DOJ
OIG
FBI
MFCU
OIG Draft Compliance Guidance for Nursing Facilities

**Intent:**
Assist NFs develop internal controls & procedures to promote compliance w/ applicable statutes and regulations for federal health care programs and private insurance programs.

- Strengthen Government’s efforts to prevent, reduce fraud & abuse
- Further the mission of all NFs to provide quality of care
Nursing Facility Risk Areas

- Quality of Care
  - Stresses the importance of compliance with quality standards
- Residents’ Rights
- Billing & Cost Reporting
- Employee Screening
- Kickbacks, Inducements, Self Referrals
- Vendor Relationships
- Record keeping & Documentation
Nursing Facility Risk Areas

- Numerous federal and state requirements
- Frequently modified
- NFs to conduct Internal Compliance Reviews
  - Baseline assessment and subsequent reevaluations of their own risk areas
  - Legal audits
  - Operational audits
- First step – comprehensive clear written standard policies & procedures communicated to all
Nursing Facility Risk Areas

Focus on those areas most likely to arise in daily operations

- "...at a *minimum* (emphasis in the original) resources directed to analyze results of annual surveys and to verify that the facility has effectively addressed the deficiencies cited.
  - The facility QA Committee

Create a resource manual — individual copies or reference copies in readily accessible locations

- "... a simple binder ..."
  - Facility’s policies & procedures
  - Most recent 2567 & POC
  - HCFA instructions & bulletins
  - OIG documents
Compliance Risk Areas

- Failure to provide accurate assessments and comprehensive care plans
- Inappropriate or insufficient treatment
  - Pressure ulcers, dehydration, malnutrition, incontinence, mental or psychosocial problems
- Failure to accommodate needs & preferences
- Failure to monitor drug usage & administration
- Inadequate staffing or improperly trained or supervised staff
- Failure to report incidents of mistreatment, abuse, neglect
Compliance Risk Areas (continued)

- Failure to provide appropriate therapy services
- Failure to provide ADL assistance
- Failure to provide an activities program to meet individual needs
- Discriminatory admissions or denial of care; abuse; improper restraints
- Failure to provide personal privacy, access to records and protect confidentiality of records
- Denial of right to participate in treatment decisions
Compliance Risk Areas (continued)

- Failure to safeguard residents’ financial affairs
- Failure to maintain all records and documentation
- Billing & claims, RAI, plans of care, plans of correction
- No gifts or gratuities
- Failure to investigate backgrounds
Nursing Home Staffing

- Staffing – level and quality
- Most common factor giving rise to quality of care allegations
- 90% of nursing homes allegedly understaffed
- CMS Staffing Studies
  - 2001; 2002
  - No firm recommendations
- Pending Federal Legislation – Nursing Home Staffing Improvement Act of 2002 – HR 4715
- 4.1 ppd
- Nursing Home Compare Reports – VA = 5.1 ppd
Likelihood of Enforcement

- Clear evidence of “harm”
- Large numbers of “victims”
- High management condoning a practice
- More and more prosecution in “gray” areas – the “egregious” bar is lower these days
- Ambitious AUSAs
Legal Authority and Covered Conduct

**Federal Laws**

- **The False Claims Act** — 31 U.S.C. sec. 3729(a) to 3733
  - A powerful enforcement tool, which enables the government to seek significant damages and penalties against providers who knowingly submit false or fraudulent bills to Medicare, Medicaid, or other federal health programs
The False Claims Act

Prohibits knowing submission of false claims to secure payment from the federal government
- Actual knowledge
- Deliberate ignorance of the truth
- Reckless disregard for the truth

Qui Tam or Whistleblower Provision
- Allows private parties to bring False Claims actions
- Individual receives a portion of the damages
The False Claims Act

- **Penalties**
  - **Civil**
    - Penalties between $5,500 and $11,000 for each claim and treble (3X) damages
  
  - **Criminal**
    - Variable fines determined on a case-by-case basis
Any person who, in any matter involving a federal health care benefit program, knowingly and willfully: falsifies, conceals, or covers up, by any trick, scheme, or device, a material fact, or makes any materially false or fraudulent statement or representation, or makes or uses any materially false writing or document knowing that it contains a materially false, fictitious, or fraudulent statement of entry, will be fined, or imprisoned, or both, for a maximum of five years.
Selected Federal Laws

- CRIMINAL PENALTIES FOR ACTS INVOLVING FEDERAL HEALTH CARE PROGRAMS Soc. Sec. Act § 1128B (42 U.S.C. § 1320a-7b)
- CIVIL MONETARY PENALTIES Soc. Sec. Act § 1128A (42 U.S.C. § 1320a-7a)
- The Criminal False Claims Act (Selected Provisions) (18 U.S.C.)
- EXCLUSION OF CERTAIN INDIVIDUALS AND ENTITIES FROM PARTICIPATION IN MEDICARE AND STATE HEALTH CARE PROGRAMS Soc. Sec. Act § 1128 (42 U.S.C. § 1320a-7)
  - Mandatory
  - Permissive
Legal Authority and Covered Conduct

Selected Virginia Laws

VA Code 63.1-55.2 Protection of Aged or Incapacitated Adults; Definitions

- "Abuse" — the willful infliction of physical pain, injury or mental anguish or unreasonable confinement
- "Neglect" — not being provided such services as are necessary to maintain physical and mental health and that failure to receive such necessary services impairs or threatens to impair well being

Residents’ Right to be free from abuse

- VA Code 32.1-138 Nursing Homes
- VA Code 63.1-182.1 ALFs
- 12 VA Admin Code 40-60-692 Adult Day Care Centers
- 12 VA Admin Code 5-380-200 HHA
Abuse – the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish.

- “This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental & psychosocial well-being.” [IG @ F 233]

- Presumes that instances of abuse in all residents, even those in a coma, cause physical harm, pain or mental anguish. [IG @ F223]
42 C.F.R. 488.301

- **Neglect** – Failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness.
- **Misappropriation** – The deliberate misplacement, exploitation or wrongful temporary or permanent use of a resident’s belongings or money without the resident’s consent.
- **Mistreatment** - ???
Virginia

**VA Code 18.2-57  Assault and Battery**
- Simple – Class 1 misdemeanor

**VA Code 18.2-369  Abuse and Neglect of Incapacitated Adults**
- No serious bodily injury – Class 1 misdemeanor
- Second + offense – Class 6 felony
- Serious bodily injury – Class 6 felony
- “Abuse” ...knowing and willful conduct that causes physical injury or pain or, knowing and willful use of physical restraint as punishment, convenience or as a substitute for treatment...
- “Neglect” knowing and willful failure...to provide treatment, care, goods or services which results in injury to the health or endangers the safety of an incapacitated adult.
Virginia

VA Code 32.1-312 Fraudulently Obtaining Excess or Attempting to Obtain Excess Benefits or Payments

- Willful False Statements
- Willful Misrepresentation or willful concealment of a material fact
- Other fraudulent scheme or device – e.g., billing for services, drugs, supplies or equipment that were unfurnished or of a lower quality or as a substitution or misrepresentation of items billed.
- Repayment with interest
- Court Order for treble damages
Virginia

VA Code 32.1-314   False Statement or Representation in Application for Payment or for Use in Determining Rights to Payment; concealment of Facts...

Any person who

- Knowingly and willfully making or causing to be made any false statement or representation of a material fact for use in determining rights to such payment, or knowingly and willfully falsifying, concealing or covering up by any trick, scheme or device a material fact in connection with such application for payment

- With knowledge of any event affecting the initial or continued right to any payment...willfully concealing or failing to disclose with the intent fraudulently to secure such payment in greater quantity or when no payment is authorized
Virginia

**Fraud Against Taxpayers Act**

- April 17, 2002
- Modeled on the Federal False Claims Act
- Establishes a *qui tam* cause of action
  - Employees must make good faith attempt to exhaust internal reporting procedures
  - Whistleblower retaliation remedies available
- Civil penalties of $5000 – $10,000 plus treble damages
- Additional recovery by Virginia for costs of a civil action
Virginia

VA Code 63.1-55.3 Protection of Aged or Incapacitated Adults; Physicians, Nurses etc., to Report Abuse, Neglect or Exploitation of Adults; Complaint by Others; Penalties for Failure to Report

- Any licensed health professional...“who has reason to suspect...(abuse, neglect or exploitation...)”
- Penalties for Failure to Report with 24 hours
  - ≤ $500 – 1st offense
  - $100 - $1000 subsequent failure to report
Virginia

- VA Code 32.1-316  Penalties for False Statements Concerning Facilities
- VA Code 18.2-260  Falsification of Medical Records
- VA Code 18.2-67.10  Sexual Abuse
- VA Code 32.1-138.4; 63.1-177.1 – Whistleblower protections
Investigations

**Signs an investigation is in process**

- **Indirect**
  - Employees
  - Grapevine

- **Direct**
  - Subpoena
  - Search Warrants

- What to do
- What not to do
Evidence in “Failure of Care” Cases

**Resident Level**
- Resident records of individual residents alleged to have been abused
- Witness Statements
- Other agencies – APS; LTC Ombudsmen
- Survey Reports
- MDS Repository Data
- Medicare and Medicaid claims data
  - DMAS files
  - Medicare CWF; FI records
Evidence in “Failure of Care” Cases

- Systemic abuse or neglect
  - All resident specific evidence (previous slide)
  - False statements regarding staffing levels, qualifications or training
  - Insufficient funds spent on raw food, supplies, or necessary therapies
  - MDS or QI that raise flags or indicate “sentinel events”
  - Immediate Jeopardy survey results; consistent SQC, actual harm or poor QOC survey results
  - Evidence of historic problems – hospitals, EMS, APS, advocacy groups
Investigations

- These are primarily document cases.
- And everything you do or have done is scrutinized once the government knocks
Facility Responses

- Cooperation but not concessions
- Experienced, Credible Health Law Counsel
- Credible Provider Spokesperson(s)
- Employee Representation
- Objective Analysis of FACTS
- Good Faith Negotiations with Government
Facility Responses

**Negotiation Objectives**

- Minimize Facility Disruptions
- Negotiate Size of Document Requests
- Copying Costs
- Focus on Specifics Rather than Wholesale Fishing Expeditions
  - What is their strongest example; main compliant or concern
- Acknowledge (internally) likelihood of settlement
Resident-Centered Outcomes

- No-action letter
- Key deal point - CMPs take $$$$ from resident-care
  - CMPs are counterproductive
  - Negotiate methods to funnel $$$ back into facility
    - Technical Assistance
      - CRIPA cases; DOJ/MFCU cases
    - Facility Monitors
      - Mutual Selection Criteria
      - Mutual Approval
Resident-Centered Outcomes

Sources of Funds

- Civil Money Penalties
  - Survey sanctions
  - FCA and state penalties
- Treble Damage Claims
- Funds from Former Management Companies
Resident-Centered Outcomes

Uses of Funds

- Settlement provisions to directly benefit residents & staff of facility
  - New positions funded
  - Hiring bonuses; education funds
  - Staffing patterns (+/-)
  - Equipment
    - Direct Resident Care
    - Dietary
      - Computer Upgrades or Acquisition
  - Capital Expenditures
  - Deep Cleaning
  - Physical Plant Repairs
Resident-Centered Outcomes

- Not limited to DOJ/MFCU FCA or CRIPA cases
  - Survey enforcement
    - Temporary Managers – paid by CMPs
    - Technical Assistance – funded by CMPs
    - Targeted QI initiatives related to alleged deficiencies
  - State Use of Medicaid CMPs
    - Quality Improvement Initiatives