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BEFORE

UNITED STATES SENATE COMMITTEE ON FINANCE

"Not forgotten: Protecting Americans against abuse and neglect in nursing homes"

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INTRODUCTION

Mr. Chairman and Members of the Committee, thank you for the opportunity to appear before you today to discuss the role of the state Medicaid Fraud Control Units ("MFCUs") in investigating and prosecuting patient abuse and neglect in nursing homes. I am Keesha Mitchell, Director of the Medicaid Fraud Control Unit in Ohio Attorney General Dave Yost's Office.

The Medicare-Medicaid Anti-Fraud and Abuse Amendments enacted by Congress in the 1970s established the state Medicaid Fraud Control Unit Program, and provided the states with incentive funding to investigate and prosecute (1) Medicaid provider fraud, (2) fraud in the administration of the Medicaid program, and (3) abuse, neglect, and misappropriation involving the residents of health care facilities. Currently forty-nine states, the District of Columbia, the U.S. Virgin Islands, and Puerto Rico have MFCUs. MFCUs are usually located in the state Attorney General's office, although some units are located in other state agencies with law enforcement responsibilities, such as the state police or the state Bureau of Investigation. While we all operate under unique state jurisdictional statutes, the MFCU model embraces the use of a "strike force" team of investigators, prosecutors, fraud analysts, and nurses.

When Congress created the MFCUs, it did so not only because of the evidence of massive fraud in the Medicaid program, but also because of the horrendous tales of nursing home abuse and neglect. The MFCUs are the only law enforcement agencies in the country that are specifically charged with investigating and prosecuting abuse and neglect of residents in nursing homes. By way of example, I offer:

Whetstone Gardens and Care Center

An Ohio grand jury recently returned indictments against seven current and former employees and contractors of Whetstone Gardens and Care Center, a nursing facility located in Columbus. The defendants are charged with Involuntary Manslaughter, Gross Patient Neglect; Patient Neglect; Tampering with Evidence; and Forgery. Through the use of a covert video surveillance camera, we were able to establish that facility employees failed to provide required care and falsified patient medical records to make it appear as though the care had been provided. Our investigation also established that a facility resident died from infected skin wounds because facility employees failed to take appropriate action that would have saved his life. This investigation is on-going, and we've received more than thirty-five additional complaints regarding care in this facility since this story aired.

Hilty Mennonite Community Nursing home

In another case, three employees of Hilty Mennonite Community Nursing Home pled or were found guilty of one count each of Forgery and Gross Patient Neglect. The defendants were employed at Hilty Mennonite Community Nursing Home on the night of January 7, 2018, when a female resident of the facility wandered outside the facility

in subzero temperatures, and died of hypothermia. Despite the fact that the resident was wearing a WanderGuard device, which was designed to alert staff when she travelled past sensors placed throughout the facility, and exited the facility through a door with an alarm sensor, the resident was not discovered missing for more than eight hours, when the morning staff was preparing residents for breakfast. The defendants, who were supposed to be caring for the resident during the nighttime hours, and documented that they checked on the resident every two hours throughout the night, admitted that they never even looked in the resident's room to see if she was there.

As you may know, Medicaid is the primary payer source for most certified nursing facility residents, with more than six in ten residents (about 832,000 people) covered by Medicaid as their primary payer in 2016. In the last ten years, the Ohio MFCU has processed nearly 3,300 complaints of abuse, neglect, and misappropriation, and posted 241 criminal convictions resulting from those complaints. Under the best of circumstances, these are challenging cases, and we are tasked with the responsibility to speak for those who are often unable to speak for themselves. While this is extremely rewarding work, our efforts are hampered by a number of factors.

SURVEYS

While we accept complaints from any and all sources, the majority of our complaints originate with our state survey agency, the Ohio Department of Health ("ODH"), and take the form of either surveys or Self-Reported Incidents. The survey agency conducts both annual and complaint surveys which, as the name would imply, are initiated in response to specific complaints. In either case, the surveyors do not conduct investigations, per se; they make determinations regarding violations based on records, on-site interviews, and on-site observations. They rarely interview staff members not present during their visit, even if they were involved in the incident. They base their citations on what they see, what they are told, and what they review. This can be problematic for various reasons. As we have confirmed in numerous investigations, facility staff are often not truthful with surveyors, the administration encourages falsification of information, and facility administrator's ramp up staffing during the survey to give the appearance of readily available staff.

There is a real need for a prompt referral to state MFCUs if the surveyors see evidence of falsification of records or have real concerns regarding neglect or abuse of residents in the facility. Currently we see a survey report after it is complete and after ODH has exited the facility. The survey and the facility response to their citations are available to the public but only several weeks after the survey. We would like to see better collaboration between the state survey agency and MFCUs throughout the country.

UNDERREPORTING

The survey agency also responds to Self-Reported Incidents which originate with the facilities themselves. As in many states, we experience problems with prompt and accurate reporting. The law requires that care facility operators promptly report to the survey agency and law enforcement any reasonable suspicion of a crime committed against a resident of the

facility, including patient abuse, patient neglect, and misappropriation. Unfortunately, the manner in which the incident is reported by the facility often minimizes the seriousness of the offense or omits relevant facts which might otherwise cause a referral to the MFCU. By way of example, I offer:

Example #1

In one example, a facility reported only that a female resident had fallen from a wheelchair during transportation in a facility van. The report indicated that the driver of the van had swerved to miss a deer in the road, and that the "effect on the resident" was that the resident said: "My behind hurts." Our investigation revealed that the resident was airlifted to a hospital with two fractures in her neck, one fracture in her lower back, and fractures of both knees. The resident died days later as a result of her injuries. During a subsequent interview with the Nursing Home Administrator, she admitted that she was intentionally vague in reporting the incident, at the direction of the facility's attorney.

Example #2

In another example, a facility reported an "injury of unknown origin" resulting from an "Incident [which] occurred outside of building." Our investigation revealed that the facility resident had eloped and drowned in a pond on the facility grounds.

In both of these examples, the facilities knew exactly what had happened to their residents, but omitted relevant facts from their reports. We can only speculate as to why certain facilities under-report, but it seems reasonable to assume that they are attempting to avoid a criminal investigation by law enforcement, a complaint survey, or a potential civil action.

It is also worthy of note that as part of a MFCU's performance standards, we are required to report convictions to HHS-OIG for their provider exclusion list. Not all prosecutorial agencies are required to do this, which magnifies the importance of involving MFCUs in the prosecution of nursing home employees. While Medicaid funded care facility providers in Ohio are prohibited from employing excluded individuals, all care facilities, regardless of how they are funded, are precluded from employing individuals identified on Ohio's Nurse Aide Registry and individuals with disqualifying criminal convictions. We would recommend that all care facilities also be prohibited from employing individuals identified in the following:

1. The Abuser Registry, Ohio Department of Developmental Disabilities
2. The Sex Offender and Child Victim Offender Database, Ohio Attorney General
3. The U.S. General Services Administration System for Award Management Database
4. The Database of Incarcerated and Supervised Offenders, Ohio Department of Rehabilitation and Corrections

REIMBURSEMENT

Finally, the "elephant" in the room is staffing; both the quantity and quality of staff and the way we reimburse nursing homes. Current funding models often incentivize facilities to maximize profit by increasing the relative complexity of care required by their patients which in turn increases their reimbursement. The policy underlying this model anticipates that the nursing home will then have to increase staff to meet the needs of their patient population. However, there still remains a financial incentive to decrease direct care staffing levels to lower operating costs, regardless of the acuity level of a nursing home's patient population. While it is important to employ quality staff over a set number of staff, our investigations have shown time and again that quality staff will leave an understaffed facility due to an inability to provide required care and fear for their licensure. Additionally many problematic facilities employ temporary agency staff who are not familiar with the patient's ongoing care. Let us be plain: If we want adequate staffing and quality of care, we are going to have to pay for it. This will likely mean more funding for long term care, and an overhaul of the Medicare and Medicaid reimbursement models.

Autumn Healthcare of Zanesville

Autumn Healthcare of Zanesville, Inc. and Steve Hitchens were convicted on January 9, 2017. The corporation was convicted of one count of Engaging in a Pattern of Corrupt Activity; one count of Medicaid Fraud; two counts of Telecommunications Fraud; two counts of Tampering with Evidence; nine counts of Forgery; and one count of Theft. Hitchens, the owner, was convicted of one count of Tampering with Evidence; one count of Tampering with Records; and one count of Forgery.

This investigation started with covert video surveillance cameras placed in residents' rooms, followed by a detailed comparison of the care evidenced on the video with the care memorialized in the residents' medical records. The investigation found that Autumn Health Care of Zanesville, through its owner and many of its managers, habitually altered official documents to falsely make it appear that it was regularly providing adequate care for its residents. Although the records reflected a high level of care, the investigation found that several patients missed treatments and were given therapy that they didn't need in order for the company to make more money. The corporation was ordered to pay restitution totaling $167,640.10, and Hitchens was sentenced to three years community control and 100 hours of community service.

COLLABORATION WITH FEDERAL LAW ENFORCEMENT PARTNERS

State MFCUs also actively participate with our federal counterparts on Elder Justice Task Forces. We believe through joint investigations, sharing information, and regular meetings, we strengthen our efforts nationally to protect the most vulnerable of our population who reside in our nursing homes and other care facilities. These task forces allow us to leverage the resources and expertise of the states and the federal government, particularly where we see chain-wide systemic patient neglect. Working together has allowed us to focus our efforts nationally on nursing home chains for failure to provide services in violation of

certain essential requirements that the state Medicaid programs expect skilled nursing facilities to meet. Examples of these failures have included an insufficient number of skilled nurses to adequately care for residents, inadequate catheter care for residents, and inappropriate care to prevent pressure ulcers or falls.

CONCLUSION

State Medicaid Fraud Control Units play a vital role in protecting our nation's nursing home residents. In order to effectively investigate incidents of patient abuse and neglect we must ensure timely referrals from State Surveyors to their MFCUs when they suspect abuse, neglect or falsification of records. We must also require nursing homes to properly report and detail incidents of patient abuse, neglect and misappropriation or face meaningful penalties. It is crucial that state and federal agencies coordinate their investigations to properly leverage our resources and expertise. Finally, states must address the real outcomes of not properly incentivizing nursing homes to adequately staff their facilities to achieve quality care.