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—from a declaration of the American Bar Association

Section 1557 of the ACA – The Future of Nondiscrimination Compliance, Risk, and Litigation for the Post-Acute and Long Term Care Industry

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It is no secret that the Affordable Care Act (ACA) has changed the future of health care in this country. But in the midst of the ACA's high-profile litigation concerning the individual mandate, contraceptive coverage, and tax subsidies—one critically important provision of the ACA has received little attention until now. That provision is Section 1557: the ACA's nondiscrimination law and the new civil rights paradigm for the health care industry. Section 1557 is the first federal civil rights law ever to focus exclusively on health care nondiscrimination—and the first to prohibit discrimination on the basis of sex in health care. And although it's flown under the radar until now, Section 1557 is certain to have a significant and long-lasting impact on the health care industry for years to come.

Introduction to Section 1557 and the Final Rule

Before the passage of Section 1557, discrimination on the basis of race, color, national origin, age, and disability by health care entities that received federal financial assistance was already prohibited.[1] These pre-existing prohibitions are what require health care providers to provide, for example, language assistance services for individuals with limited English proficiency (LEP) and auxiliary aids for hard of hearing or deaf individuals.[2]

But Section 1557 and its final regulatory rule have dramatically expanded the scope of these protections. For example, Section 1557 now prohibits discrimination on the basis of "sex" in health care.[3] In the final rule, The Department of Health and Human Services Office for Civil Rights (OCR) interprets this new prohibition to also cover discrimination on the basis of "pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, sex stereotyping, and gender identity."[4]

In addition, Section 1557 and the final rule expand upon health care providers' pre-existing duty to provide meaningful access to LEP patients. For example, the final rule requires covered providers to provide oral interpretation services where it is "reasonable" to do so.[5] Covered providers must also now use "qualified" interpreters and translators, as defined by the regulation.[6] And now under the final rule, the determination as to whether a covered provider is meeting its meaningful access obligations will largely depend on whether that provider has adopted and implemented a language access plan.[7]

Section 1557's regulatory overlay also requires covered providers to take immediate action to comply with the law's nondiscrimination requirements. For example, if a covered health care provider has 15 or more employees, that provider must:

- designate an employee responsible for coordinating compliance with Section 1557 and the final rule;
- adopt a grievance procedure to promptly and equitably resolve complaints of discrimination; and
- post nondiscrimination notices, which must include language assistance "taglines" translated into the top 15 languages spoken on a state-wide basis.[8]

These nondiscrimination notices must be posted conspicuously in public spaces, on a provider's website, and in all "significant communications or publications."[9] For significant communications or publications that are "small sized," a covered provider must post a smaller nondiscrimination statement with two taglines.[10]

This final rule went into effect on July 18, 2016, although covered providers had until October 16, 2016 to post the notices and taglines.[11]

To facilitate compliance with these regulations, OCR has supplied in the final rule a sample nondiscrimination notice and statement, the taglines translated into multiple languages, and a sample grievance procedure that satisfies the rule's requirements.[12]

Interpretations of Section 1557 in the Final Rule

In the final rule, OCR also adopted several significant interpretations of Section 1557 that will receive *Chevron* deference in the courts moving forward.

As mentioned above, OCR has interpreted "sex" to protect against discrimination on the basis of gender identity.[13] And although OCR declined to interpret "sex" as protecting against discrimination on the basis of sexual orientation, OCR expressly stated that it will evaluate complaints of discrimination on the basis of sexual orientation to determine whether such complaints are actionable under Section 1557.[14]

OCR also interprets Section 1557 as providing for a private cause of action and for compensatory damages to private plaintiffs.[15]

Disparate Impact Risk in Health Care: A New Era of Discrimination Litigation

Perhaps most impactful, however, is OCR's express interpretation of Section 1557 as providing for a private cause of action for a disparate impact claim of discrimination in health care.[16]

Under such an interpretation, any private plaintiff (e.g. a single patient, a class of patients, or a civil rights group employing an impact litigation strategy) may challenge a facially neutral policy or practice that disproportionately impacts any protected class under Section 1557.[17] It cannot be overemphasized that this interpretation—if upheld by the courts—would usher in a new era of health care discrimination litigation.

Indeed, before Section 1557, this cause of action did not exist on the basis of race, color, or national origin (or sex, for that matter).[18] That is because in 2001, the Supreme Court ruled that there is no private right of action for disparate impact discrimination under Title VI of the Civil Rights Act of 1964.[19] As a result of this ruling, a private individual could only bring a claim for *intentional discrimination* (disparate treatment) on the basis of race, color, or national origin.[20] Only OCR could bring a *disparate impact* claim for discrimination in the provision of health care services.[21] Because OCR's resources are quite limited, the Court's decision in *Alexander* made disparate impact litigation in the health care industry virtually non-existent.[22]

But the potential impact of a disparate impact claim is exemplified by an investigation by OCR in 2009. There, the University of Pittsburgh Medical Center sought to close one of its hospitals—which would have had a disparate impact on the poorer African American neighborhood in which it was located. OCR, pursuant to its obligation to enforce Title VI, ultimately reached an agreement with the health system whereby UPMC agreed to: (1) subsidize expanded hours and services at a federally qualified health center; (2) provide door to door transportation for residents to three outpatient facilities in a neighboring community; (3) provide door to door service to another UPMC affiliated hospital; (4) conduct six health-screening programs throughout the year as well as a diabetes-screening program twice a year; (5) designate an ombudsperson to help individuals navigate the UPMC health care system; and (6) provide outreach to faith-based health ministries in the community.[23]

Under OCR's interpretation of Section 1557, any private plaintiff could bring a similar challenge to any similar health care facility closure or relocation.

Another potential target of disparate impact claims: policies or practices that limit a provider's exposure to low-income or Medicaid patients. For example, on December 15, 2014, the Mexican American Legal Defense and Educational Fund, together with the National Health Law Program, filed an administrative civil rights complaint with OCR targeting the low reimbursement rates of California's Medi-Cal program

on the theory that low reimbursement rates have a disproportionate impact on the Latino men and women who are overrepresented among Medi-Cal enrollees compared to other groups.[24] Under the same theory, a long term care provider (for example) that limits its number of Medicaid beds would be vulnerable to a disparate impact challenge because protected minorities are overrepresented in the Medicaid program.

Disparate impact claims under Section 1557 will also likely be used to challenge health care providers' meaningful access plans for LEP patients. Remember, under *Alexander*, a private party could not bring a disparate impact claim under Title VI to challenge *unintentional* national origin discrimination (the basis of the meaningful access requirements). But now, under Section 1557, any private plaintiff may do so. This means that an LEP patient that is not provided meaningful language access by a provider could challenge that provider's meaningful access policies on a *system wide basis*—and not be required to show intentional discrimination.

Private and Federal Enforcement Under Section 1557

As this discussion makes clear, Section 1557 will be enforced both privately and federally. For example, not only may a private plaintiff now bring disparate impact discrimination claims against entire health systems, but Section 1557 can also serve as the basis for health care discrimination class actions. In one recent example, a putative class action alleging intentional and disparate impact disability discrimination was brought under Section 1557 against a health insurer. *See East v. Blue Cross and Blue Shield of Louisiana*.[25] In that case, the plaintiff was able to successfully obtain a temporary restraining order preventing the insurer from changing its policies which would adversely affect patients with HIV.[26]

Of course, apart from this private enforcement available under Section 1557, OCR is the office tasked with enforcing Section 1557 and the final rule at the federal level. The final rule makes clear that Section 1557 will be enforced in a similar way as to other health care laws. For example, where compliance with Section 1557 and its regulations cannot be ensured by informal means, the rule authorizes suspension and termination from federal programs as well as enforcement proceedings brought by the Department of Justice. To ensure compliance, a covered entity must also keep records and submit compliance reports to OCR as demanded.

So far, OCR has vigorously enforced Section 1557's new protections on the basis of "sex." For example, in August of 2015, OCR reached a settlement with The Brooklyn Hospital Center in New York after it assigned a transgender female to a double occupancy room with a male occupant. As part of the two-year settlement agreement, the medical center agreed to adopt and train employees on new policies and procedures tailored to transgender patients that address everything from admissions and room assignments, to documenting patients' "legal and a preferred name" and their "gender and/or transgender status, if the Patient has identified that status and agrees that it should be recorded."

Post-Acute and Long Term Care Providers Should Take Action Now

As this discussion makes clear, Section 1557 and the final rule require immediate action on the part of health care providers so as to comply with the ACA's nondiscrimination provisions. Therefore, in light of Section 1557's new requirements, and to minimize their risk under the final rule, post-acute and long term care providers should take the following steps.

First, providers should comply with the final rule by:

a. Designating an employee responsible for ensuring compliance with Section 1557 and the rule;

b. Adopting a grievance procedure to promptly and equitably resolve complaints of discrimination;

c. Having posted the required nondiscrimination notices and taglines by October 16, 2016;

Second, providers should revise their nondiscrimination policies and procedures (e.g. admission and room assignment policies) to account for the expansion in protected classes under Section 1557 and the final rule (e.g., sex and gender identity). Third, providers should evaluate their disparate impact risk. This would require evaluating plans regarding closures and relocations of various facilities, as well as policies related to low-income and Medicaid patients. Fourth, providers should ensure that that are meeting their meaningful access language obligations by creating and implementing a language access plan. And finally, providers should monitor any legal developments in the courts. Indeed, the law of Section 1557 is likely to develop on a monthly (if not weekly) basis moving forward—and as it develops, providers need to stay informed.

Conclusion

Section 1557 and its final rule are certain to have a significant and long-lasting impact on the post-acute and long Term care industry. Under the final rule, providers must take immediate action so as to comply with the ACA's nondiscrimination provisions. In addition, Section 1557 has expanded a provider's risk of facing discrimination litigation by creating new protected classes and new causes of action. Therefore, it is imperative that providers take action now to minimize their risk moving forward.

1 *See, e.g.*, Sidney D. Watson, *Section 1557 of the Affordable Care Act: Civil Rights, Health Reform, Race, and Equity*, 55 HOW. L.J. 855 (2012).

2 *See, e.g.,* Joel Teitelbaum, et al., Translating Rights into Access: Language Access and the Affordable Care Act, 38 AM. J.L. & MED. 348 (2012); Laura F. Rothstein, Introduction to the Health Law Symposium Issue: Celebrating the Tenth Anniversary of the Americans with Disabilities Act, 37 HOUS. L. REV. 979 (2000).

3 Section 1557 reads in relevant part:

> An individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964, title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, or section 504 of the Rehabilitation Act of 1973, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments). The enforcement mechanisms provided for and available under such title VI, title IX, section 504, or such Age Discrimination Act shall apply for purposes of violations of this subsection.

Pub. L. 111-148, § 1557; 42 U.S.C. § 18116.

4 Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. 54172, 54176 (proposed Sept. 8, 2015) (to be codified at 45 C.F.R. pt. 92) ("The term 'on the basis of sex' is defined to include, but is not limited to. . . sex stereotyping, or gender identity.") [hereinafter *Nondiscrimination in Health Programs and Activities*].

5 *Nondiscrimination in Health Programs and Activities* at 31470.

6 *Id.*

7 *Id.*

8 *Id.* at §§ 92.7-.8.

9 *Id.* at 31469.

10 *Id.*

11 *Id.*

12 *See* Appendices A. B, and C to *Nondiscrimination in Health Programs and Activities*.

13 *Id.* at 31384. Notably, on August 23, 2016, several faith-based providers and states filed suit against HHS challenging this interpretation. *Texas v. Burwell*, 7:16-cv-00108-O (N.D. Tex. Aug. 23, 2016). In this suit, the plaintiffs argue: (1) that HHS exceeded its rulemaking authority by expanding the reach of the term "sex" from its meaning in Title IX; (2) that HHS unconstitutionally infringed on the states' sovereign authority to regulate the medical profession; and (3) that the final rule violates the Religious Freedom Restoration Act. Undoubtedly, the ultimate outcome of this case will significantly impact the reach of Section 1557—and influence how the federal courts interpret it.

14 *Nondiscrimination in Health Programs and Activities* at 31390.

15 *Id.* at § 92.301.

16 *Id.* at 31440 ("OCR interprets Section 1557 as authorizing a private right of action for claims of disparate impact discrimination on the basis of any of the criteria enumerated in the legislation.").

17 *See, e.g.,* Sarah G. Steege, *Finding a Cure in the Courts: A Private Right of Action for Disparate Impact in Health Care*, 16 MICH. J. RACE & L. 439 (2011) [hereinafter *Finding a Cure in the Courts*].

18 *See id.*

19 *See Alexander v. Sandoval*, 532 U.S. 275, 293 (2001).

20 *See Finding a Cure in the Courts* at 441-43.

21 *See id.*

22 *See id.*

23 *See* http://wayback.archive-it.org/3926/20131018160613/hhs.gov/news/press/2010pres/09/20100902c.html.

24 *See* Press Release, SEIU-United Healthcare Workers West, California Violates Civil Rights of Latinos Receiving Medi-Cal, Complaint to U.S. Dept of Health and Human Services Alleges: Low Reimbursement Rates Limit Access to Care (Dec. 15, 2015), *available at* http://www.businesswire.com/news/home/20151215005680/en/California-Violates-Civil-Rights-Latinos-Receiving-Medi-C.

25 2014 WL 8332136 (M.D. La. Feb. 24, 2014).

26 *See id.*

Snapchat, Facebook, and Instagram, Oh My! Social Media, Resident Abuse, HIPAA, and Long Term Care

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The long term care profession is making headlines these days with reports of the use of social media to exploit the residents in its protection.[1] Social media are web-based communication tools that enable people to interact with each other by both sharing and consuming information.[2] Long term care employees have gotten in trouble for their use of social media, such as Facebook, Snapchat, Instagram, and YouTube, to disseminate inappropriate images and videos of residents.

CMS Addresses Social Media and Abuse and Privacy Concerns

The Centers for Medicare & Medicaid Services (CMS) has acted upon its social media concerns with the release of a memorandum, "Protecting Resident Privacy and Prohibiting Mental Abuse Related to Photographs and Audio/Video Recordings by Nursing Home Staff," published on August 5, 2016 (CMS Memo).[3] The CMS Memo provides that residents have the right to be free from all types of abuse, including mental abuse, defined to include "abuse that is facilitated or caused by nursing home staff taking or using photographs or recordings in any manner that would demean or humiliate a resident[]."[4] The CMS Memo advises that surveyors must conduct an abuse investigation "[i]f a photograph or recording of a resident, or the manner that it is used, demeans or humiliates a resident[], regardless of whether the resident provided consent and regardless of the resident's cognitive status…."[5] Examples of mental abuse include taking photographs or recordings of residents that are "demeaning or humiliating" and keeping or distributing them through social media or multimedia messages.[6] In certain circumstances, the behavior may also be viewed as physical and/or sexual abuse.[7]

The CMS Memo explores how the use of photographs or recordings of residents is also a violation of residents' rights to privacy and confidentiality under federal law. There are similar violations under state law.[8] For instance, in Illinois, the residents right to privacy and confidentiality provides that "the resident has the right to personal privacy and confi-

dentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups…."[9] The CMS Memo uses common examples such as pictures of a resident eating in the dining area or participating in an activity in the common area.[10] Many long term care employees may not understand that innocently sharing pictures of residents eating dinner might be viewed as a violation of the resident's rights to privacy and confidentiality. Of course, more egregious examples of abuse are proliferating on the internet, such as pictures of residents naked or using the restroom.[11]

CMS further requires that facilities incorporate social media into a facility's abuse prevention policies. The policies must provide that facility staff are prohibited from taking or using photographs or recordings in any way that would demean or humiliate a resident, which includes using cameras and smart phones "to take, keep, or distribute photographs and recordings on social media."[12] Not only do facilities need to review and revise their abuse prevention policies, CMS is mandating that facilities provide abuse training on this issue, along with ongoing oversight of the policy implementation.[13]

The CMS Memo reminds facilities that any allegation of abuse requires immediate reporting to appropriate individuals and agencies, along with an investigation to prevent further potential abuse. Based on the facility's findings, corrective actions must also be put in place.[14] Further, this duty to report dovetails with a facility's obligations pursuant to the Elder Justice Act.[15]

Facilities that do not address photographs or videos of residents or social media in their policies must act fast to get into compliance with the new requirements. As of September 5, 2016, surveyors must on the next standard survey, request and review policies and procedures related to prohibiting nursing home staff from taking or using photographs or recordings in any manner that would demean or humiliate a resident.[16]

If the survey agency receives an allegation of abuse, it must investigate onsite to determine compliance with the federal requirements, and discover whether:

- Unauthorized photographs or recordings of a resident have been taken, kept, and/or distributed on social media or transmitted through multimedia messaging by staff; or
- A photograph or video itself, or the manner that it is used, humiliates or demeans a resident.[17]

The onsite investigation must begin within two to ten days, depending on the severity of the allegation.[18]

Social Media and HIPAA

The CMS Memo is a strong indicator that the federal and state governments are paying close attention to privacy concerns in long term care. However, the memorandum does not address the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Under HIPAA, "full face photographic images and any comparable images" are considered protected health information (PHI).[19] PHI relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.[20] In other words, photographs and videos of nursing home residents meet the definition of PHI, and must be protected in accordance with HIPAA. This means that a facility cannot use or disclose pictures or videos of residents without resident authorization, unless HIPAA permits or requires the use or disclosure.[21] An example where it would be appropriate to disclose PHI without authorization would be to report resident abuse.[22]

The Department of Health and Human Services (HHS) Office for Civil Rights (OCR) has recently utilized HIPAA to address a nursing facility resident privacy violation. A

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business associate to six skilled nursing facilities settled a matter with OCR for violations of the HIPAA Security Rule after the theft of a mobile device compromised the PHI of 412 nursing home residents. The business associate, Catholic Health Services of the Archdiocese of Philadelphia, made a monetary payment of $650,000 and entered into a corrective action plan with OCR.[23] Another long term care provider, Hospice of North Idaho, was the first entity to settle with OCR for a breach involving fewer than 500 individuals.[24]

The long term care social media problem has also caught the eye of Iowa Senator Charles Grassley. On August 3, 2016, Grassley sent letters to both OCR and the Department of Justice (DOJ) asking why they have not done anything with respect to the abuse of nursing home residents through the use of social media. To OCR: "The Health Insurance Portability and Accountability Act (HIPAA) is a patient privacy law within OCR's jurisdiction. As such, OCR is responsible for investigating nursing home abuse allegations relating to privacy, which would include exploitation of residents via photography."[25] And to DOJ, he asks a similar series of questions, including:

> On the HHS Office of Civil Rights website, it notes that as of May 31, 2016, 575 criminal referrals were made to the Department of Justice relating to HIPAA violations. Of those, how many dealt with HIPAA violations in nursing homes? Of those, how many involved social media related abuse? And finally, how many were prosecuted by the DOJ and what were the outcomes?[26]

Social Media Use Can Lead to Severe Consequences for Long Term Care Facilities

States are also pursuing their own initiatives. In the Indiana matter noted at the outset of this article, the nurse aide who posted a video to Snapchat of a naked resident in the shower while using profanity and spraying water on the resident, caused the residential care facility to be placed in an immediate jeopardy status. Immediate jeopardy status has taken on new significance for nursing homes in light of another recent memorandum from CMS. In accordance with this guidance, CMS must issue civil money penalties when an immediate jeopardy status is cited, and must do so before the facility has had an opportunity to correct the problem.[27]

Long Term Care Social Media Guidance

Prior to the CMS Memo, the long term care profession was becoming more aware of the potential for use and misuse of social media and technology and was taking self-enforcement measures. The American Health Care Association/National Center for Assisted Living (AHCA/NCAL) released a memorandum on June 10, 2016 that explains the profession's concern, offers some basic understanding of social media, and provides guidance to facilities on the development of appropriate policies and procedures.[28] AHCA/NCAL advises that a social media policy should protect residents, employees, and the facility, and should operate as a roadmap for what the facility expects from its employees in their use of social media.[29]

But Wait! Employees Have Rights Too

In drafting social media policies consistent with government and trade group guidance, nursing facilities must remain aware of certain protections available to employees under state and federal laws.

With social media policies, the National Labor Relations Board (NLRB) has required that policy language explicitly delineate between prohibited conduct, on the one hand, and activities protected by the rights employees have to organize and discuss conditions of employment (rights protected by the National Labor Relations Act (NLRA)) on the other hand. The NLRB has jurisdiction over unionized and non-union employers. As AHCA/NCAL observed in its memorandum, the NLRB has scrutinized, and even invalidated, policies that broadly prohibit social media content harmful to the company or its clients.[30] NLRB has directed instead that, employers must draft social media policies precisely so as not to give the impression of forbidding discussions about terms and conditions of employment. Companies have achieved the requisite precision by incorporating into their policies specific examples of unacceptable conduct, hypothetical scenarios, or definitions.

During an investigation, long term care facilities must take caution when seeking private or confidential information from an employee regarding the employee's use of social media. Many states have privacy laws that restrict access to this information. For example, in Illinois, an employer cannot request or require that an employee furnish a user name, password, or other account information in order to gain access to the employee's personal online account.[31] Nor can an employer demand that the employee access the account in the presence of management.[32] Instead, the employer must ask the employee to furnish *specific content* from the account that has been reported to management, making clear that the purpose of doing so is to evaluate legal compliance or potential workplace policy violations.[33]

When employee discipline becomes necessary, long term care providers should review any potential adverse employment actions with counsel to assess the risks in view of the NLRB's "social media termination" cases. In the social media termination cases, the NLRB has ordered an employee reinstated (among other remedies), despite the employee's inappropriate conduct or breach of client confidentiality. In these cases, the NLRB found the social media content to have amounted to protected organizing or discussions of employment conditions.[34] If the employee received the discipline under a specific workplace policy, the NLRB sometimes has invalidated the policy itself.[35] Although unlawful or potentially dangerous

conduct by employees seldom qualifies for protection, the regulatory environment created by the NLRB requires that all terminations merit close review. For example, an illegal Facebook posting of a resident in an embarrassing position likely does not qualify for protection under the NLRA, but a discussion on Facebook among facility employees about a photograph of faulty equipment in a resident's room, may strike an NLRB administrative law judge as a protected conversation about work conditions. Likewise, an inappropriate and profane discussion by a group of employees about how a resident treats them (provided the resident remains anonymous) might also be considered protected.

Conclusion

Now is the time for long term care facilities to review and update their privacy and social media policies and procedures. Does your abuse reporting policy address the use of social media or photographs or videos of residents? Does your abuse reporting policy cross-reference your HIPAA policies and procedures to address the use of photographs and videos of residents? What about your employment policies? Do your employment policies and procedures appropriately address the use of photography, videos, and social media? These are just some of the considerations for facilities in this rapidly evolving area of law. In an era in which practically everyone carries a concealed recording device in the form of a smart phone and in which embarrassing video recordings can circle the globe in minutes via social media, personal privacy becomes increasingly more difficult to protect.

1 Tricia Harte, *Snapchat video of naked nursing home patient leads to charges*, 16 WNDU (Feb. 19, 2016), www.wndu.com/content/news/Nursing-Asst--369466662.html; *Nursing home workers fired over inappropriate photo*, USA Today (Aug. 3, 2013), www.usatoday.com/story/news/nation/2013/08/03/nursing-home-workers-fired-after-posting-photo/2615363/ (citing The Des Moines Register, August 3, 2013).

2 American Health Care Association/National Center for Assisted Living, *Social Media Guidance for Nursing Care Centers and Assisted Living Communities* (June 10, 2016) (citing Daniel Nations, *What Is Social Media? Explaining the Big Trend*) http://webtrends.about.com/od/web20/a/social-media.htm) (last visited Aug. 25, 2016).

3 U.S. Dep't Of Health & Human Servs., Ctrs. For Medicare & Medicaid Servs., *Protecting Resident Privacy and Prohibiting Mental Abuse Related To Photographs And Audio/Video Recordings By Nursing Home Staff*, S&C: 16-33-NH (2016), www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions-Items/Survey-and-Cert-Letter-16-33.html.

4 *Id*. at 1; 42 C.F.R. § 483.13(b) (2016).

5 *Id*. at 2. The CMS Memo provides detailed examples of what is included in this analysis, such as "photographs and recordings of residents that contain nudity, sexual and intimate relations, bathing, showering, toileting." *Id*.

6 *Id*. at 3.

7 *Id*.

8 *See, e.g.*, 210 ILCS 45/2-101 *et seq*.

9 *Protecting Resident Privacy and Prohibiting Mental Abuse Related to Photographs and Audio/Video Recordings by Nursing Home Staff*, *supra* note 3 at 2, citing 42 C.F.R. §483.10(e). Illinois law provides that "A resident shall be permitted respect and privacy in his medical and personal care program. Every resident's case discussion, consultation, examination and treatment shall be confidential and shall be conducted discreetly, and those persons not directly involved in the resident's care must have his permission to be present." 210 ILCS 45/2-105.

10 *Protecting Resident Privacy and Prohibiting Mental Abuse Related to Photographs and Audio/Video Recordings by Nursing Home Staff*, *supra* note 3 at 2.

11 *See, e.g.*, Charles Ornstein, *Inappropriate Social Media Posts by Nursing Home Workers, Detailed*, ProPublica (December 10, 2015), www.propublica.org/article/inappropriate-social-media-posts-by-nursing-home-workers-detailed.

12 *Protecting Resident Privacy and Prohibiting Mental Abuse Related to Photographs and Audio/Video Recordings by Nursing Home Staff*, *supra* note 3 at 3 (citing 42 C.F.R. § 483.13(b)–(c) (2016)).

13 *Id*. at 4 (citing 42 C.F.R. § 483.13(c) (2016) and 42 C.F.R. § 483.75(e)(2)–(4) (2016)).

14 *Id*. at 4.

15 *Id*. at 5 (citing U.S. Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., Reporting Reasonable Suspicion of a Crime in a Long-Term Care Facility: Section 1150B of the Social Security Act, S&C: 11-30-NH (2011), www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/scletter11_30.pdf.

16 *Protecting Resident Privacy and Prohibiting Mental Abuse Related to Photographs and Audio/Video Recordings by Nursing Home Staff*, *supra* note 3 at 5.

17 *Id*. at 6.

18 *Id*.

19 45 C.F.R. § 164.514 (2016).

20 45 C.F.R. § 160.103 (2016).

21 45 C.F.R. § 164.508 (2016); 45 C.F.R. § 164.512 (2016).

22 45 C.F.R. § 164.512(c) (2016).

23 *Business Associate's Failure to Safeguard Nursing Home Residents' PHI Leads to $650,000 HIPAA Settlement*, U.S. Dep't of Health & Human Servs., www.hhs.gov/hipaa/for-professionals/compliance-enforcement/agreements/catholic-health-care-services/index.html (last visited Aug. 25, 2016). the settlement and correction action plan were agreed to on June 24, 2016.

24 *HHS announces first HIPAA breach settlement involving less than 500 patients*, U.S. Dep't of Health & Human Servs. (Jan. 2, 2013), www.hhs.gov/about/news/2013/01/03/hhs-announces-first-hipaa-breach-settlement-involving-less-than-500-patients.html.

25 Senator Charles E. Grassley, Chairman, Committee on the Judiciary, U.S. Senate, August 3, 2016, Letter to Jocelyn Samuels, Director, Office of Civil Rights, Dep't of Health and Human Servs.

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27 *Mandatory Immediate Imposition of Federal Remedies and Assessment Factors Used to Determine the Seriousness of Deficiencies for Nursing Homes*, U.S. Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs. (July 22, 2016, revised July 29, 2016), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions-Items/Survey-and-Cert-Letter-16-31.html.

28 American Health Care Association/National Center for Assisted Living, *Social Media Guidance for Nursing Care Centers and Assisted Living Communities* (June 10, 2016).

29 *Id*. at 3.

30 *Id*. at 4; *see* Three D, LLC, 361 N.L.R.B. No. 31 (2014), *aff'd*, 629 Fed. Appx. 33 (2d Cir. Oct. 21, 2015); Durham School Services, L.P., 360 N.L.R.B. No. 85 (2014).

31 820 ILCS 55/10(b)(1)(A), (B) (Illinois Right to Privacy in the Workplace Act).

32 *Id*. at 55/10(b)(3)(C).

33 *Id*.

34 *See* Pier Sixty, LLC, 362 N.L.R.B. No. 59 (2015); Three D, 361 N.L.R.B. No. 31 (2014), *aff'd*, 629 Fed.Appx. 33 (2d Cir. Oct. 21, 2015).

35 *See* Three D, 361 N.L.R.B. No. 31.

A Matter of Opinions: The Medicare Hospice Benefit and the Standard of Objective Falsity Under the FCA

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The Medicare Hospice Benefit (MHB) has long been the subject of False Claims Act (FCA) investigations and litigation. Recent settlements with the Department of Justice (DOJ) and the Department of Health and Human Services' Office of Inspector General (OIG) have seen hospice providers pay millions of dollars to resolve FCA matters based on allegations that, in one form or another, they fraudulently submitted claims for reimbursement to Medicare for patients that did not meet the MHB's eligibility requirements.

Two decisions from within the last year—*Unites States v. AseraCareland United States ex rel. Wall v. Vista Hospice Care, Inc.*[2]—highlight the growing body of case law in the area of FCA matters based upon alleged hospice false certifications. In both of these cases, the hospice providers were able to convince the court that a physician's decision to certify a particular patient as MHB-eligible is inherently subjective and therefore, should not serve as a basis for FCA liability. This article discusses those holdings and examines how they contribute to the developing legal standard for "objective falsity" in FCA cases dealing with hospice eligibility certifications.

The Medicare Hospice Benefit

As a benefit under Medicare Part A, the MHB is administered by the Centers for Medicare and Medicaid Services (CMS) and is paid out as a fixed, predetermined fee based on the type of care provided by the hospice.[3] For eligible beneficiaries, the MHB provides two 90-day benefit periods, followed by an unlimited number of 60-day benefit periods.[4] At the end of each period, a physician must recertify that the beneficiary continues to meet the MHB eligibility requirements.[5]

In order to be eligible for the MHB, an individual must be entitled to Medicare Part A payments and must be certified as "terminally ill,"[6] which is defined to mean "that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course."[7] Certification of terminal illness must be obtained in written form and be based on the clinical judgment of: (a) the hospice medical director or a physician in the hospice interdisciplinary group (IDG);[8] or (b) the individual's attending physician (if any).[9] The hospice "admits a patient only on the recommendation of the medical director in consultation with, or with input from, the patient's attending physician (if any)."[10] If the hospice cannot obtain written certification within two calendar days after the beginning of the initial period, it must obtain oral certification within two calendar days thereafter and is not permitted to bill Medicare until it obtains such written certification.[11] Moreover, the medical director may not certify an individual as terminally ill more than 15 calendar days prior to the effective date of the patient's decision to elect hospice care, nor can the medical director complete a recertification more than 15 calendar days prior to the start of the subsequent benefit period.[12]

As CMS reaffirmed in a 2013 final rule, "eligibility for hospice services under the [MHB] has always been based on the prognosis of the individual . . . ."[13] Broader than a diagnosis, a prognosis "takes into account the diagnoses and all other things that relate to a patient's life expectancy."[14] As such, in making the initial certification as to terminal illness (and thus eligibility for the MHB), the hospice medical director must consider at least the following information: (a) the primary terminal condition; (b) related diagnosis(es), if any; (c) current subjective and objective medical findings; (d) current medication and treatment orders; and (e) information about the medical management of any of the patient's conditions unrelated to the terminal illness.[15] Moreover, in addition to certifying that the individual's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course, the medical director's certification must include "[c]linical information and other documentation that support the medical prognosis," as well as a "brief narrative explanation of the clinical findings that supports a life expectancy of 6 months or less as part of the certification and recertification forms. . . ."[16]

Of course, as CMS has long recognized, "[p]redicting of life expectancy is not always exact," and "[t]he fact that a beneficiary lives longer than expected in itself is not cause to terminate [the MHB]."[17] Thus, in determining MHB eligibility, certifying physicians "need not be concerned"[18] about

liability so long as the physician believes, based on his or her medical judgment, that the patient in question has a life expectancy of six months or less.[19]

The FCA and the "Falsity" of a Claim

The FCA makes it unlawful to, among other things, knowingly present (or cause to be presented) a "false or fraudulent" claim for payment to the government.[20] Although the plaintiff in an FCA suit (whether the government or a private whistleblower) must establish the elements of scienter and materiality, (and in some cases, causation), the crux of a viable FCA complaint is the falsity of the claim presented to the government.[21]

In most cases, a hospice provider's submission of MHB claims for patients it knows are not eligible for the MHB would meet the legal standard for objective falsity under the FCA. For example, in 2013, the government entered into a $3 million settlement with Hospice of the Comforter, Inc. (HOTCI) based on allegations that HOTCI directed its staff to admit all referred patients without regard to whether they were eligible for the MHB.[22] Additionally, HOTCI allegedly falsified medical records to make it appear as though certain hospice patients were eligible for the hospice benefits.[23] HOTCI was further accused of employing field nurses without hospice training and establishing procedures to limit physicians' roles in assessing patients' terminal status.[24]

Over the years, courts in FCA cases have fleshed out the distinction between objective falsity and mere differences of opinion for purposes of proving falsity. As explained by the Tenth Circuit, objective falsity under the FCA "does not mean 'scientifically untrue'; it means 'a lie.'"[25] In other words, "liability under the FCA must be predicated on an objectively verifiable fact" rather than a subjective opinion that the claim is false.[26]

Pertinently, in FCA cases based upon allegedly incorrect clinical judgments by a physician or other provider (e.g., a physician's opinion that a patient has six months or less to live), several courts have held that "[e]xpressions of opinion, scientific judgments, or statements as to conclusion about which reasonable minds may differ cannot be false."[27] As such, questions about a "provider's judgment regarding a specific course of treatment" are not sufficient to provide a basis for suit under the FCA.[28] According to this line of cases, because a judgment call is inherently subjective, it

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cannot rise to the level of objective falsity required to establish liability under the FCA.

Objective Falsity versus Subjective Clinical Judgments: Recent FCA Hospice Cases

As noted, in the context of FCA matters involving hospice eligibility, proving objective falsity requires a showing that certifying physicians and hospice directors knew their patients were not terminally ill.[29] Yet, as the courts in *AseraCare* and *Vista Hospice* demonstrate, such a showing requires more than a mere difference of opinion between the government's expert witness and the certifying physician as to the patient's eligibility for hospice care. In holding that competing expert testimony is not, by itself, enough to establish the falsity of a hospice's MHB claims, the two courts applied previously established FCA principles of objective falsity versus subjective clinical judgments.

U.S. v. AseraCare

In November 2012, the DOJ filed an FCA complaint against AseraCare, Inc., a for-profit chain of hospice providers.[30] The complaint alleged that, beginning in early 2007, AseraCare knowingly submitted (or caused the submission of) false claims and created false records in order to receive payments under the MHB.[31] Specifically, the government contended that many of AseraCare's Medicare patients "were not eligible for hospice care paid for by the Medicare Program because they did not have a prognosis of six months or less to live if the illness runs its normal course."[32]

From 2012 until the court's final ruling in March 2016, the case wound through a lengthy procedural process. Initially, the trial court granted the government's pre-trial motion to allow the use of sampling both in order to establish falsity and, ultimately, calculate damages.[33] To prove liability, the government relied on the deposition testimony and report of its medical expert, Dr. Solomon Liao. After reviewing a sample of 233 patients, Dr. Liao testified in a deposition that 124 patients admitted to AseraCare (and for whom claims had been submitted to Medicare) were, in his opinion, ineligible for the MHB.[34] Based on this evidence, the court denied AseraCare's initial motion for summary judgment; however, the trial judge did grant AseraCare's motion to bifurcate the trial into two phases.

Phase I required the government to prove that AseraCare's claims were objectively false. Thus, at trial, the government again called upon Dr. Liao to testify as to why, in his opinion, the patients' medical records did not support their eligibility for hospice care. However, AseraCare called its own experts, who "pointed to different pages from the patients' medical records that in their opinion showed that the patients were eligible for hospice."[35] At the close of the nearly two-month Phase I trial, the jury rendered a verdict finding that 104 claims submitted by AseraCare were objectively false.[36]

Phase II called for the court to conduct a separate trial on all other claims and issues, including the knowledge and damage elements of the government's claims. However, shortly after the conclusion of the Phase I trial, and upon oral motions from AseraCare, the court issued an opinion stating that it had "committed reversible error in failing to provide the jury with complete instructions as to what was legally necessary for it to find that the claims before it were false."[37] Concluding that it "should have advised the jury that (1) 'the FCA requires 'proof of an objective falsehood,' [citations omitted]; and (2) a mere difference of opinion, *without more*, is not enough to show falsity," the court granted AseraCare's motion for a new trial on the issue of falsity.[38] In doing so, the court further explained its rationale:

> When two or more medical experts look at the same medical records and reach different conclusions about whether those medical records support the certifying physicians' COTIs [Certifications of Terminal Illness], all that exists is a difference of opinion. This difference of opinion among experts regarding the patients' hospice eligibility *alone* is not enough to prove falsity, and the Government has failed to point the court to any *objective* evidence of falsity.[39]

The case never reached a second Phase I trial. On a renewed motion for summary judgment by AseraCare in March 2016, the court held that "the Government's proof on the falsity element fails as a matter of law" and granted the motion as to all remaining counts in the complaint.[40]

Importantly, the court in *AseraCare* emphasized that "[t]he Government has repeatedly stated that the *only* evidence it is using to prove falsity of the claims for the patients at issue is the testimony of Dr. Liao, who offered *his opinion, based on his clinical judgment*, about the eligibility of the patients at issue, and the accompanying medical records for each patient."[41] The court stated that, although the medical opinion of their own expert was, standing alone, not enough to prove falsity, the government could have coupled that expert opinion "with anticipated evidence that AseraCare staff falsified information in the records, or withheld or misrepresented information from the certifying doctor," which could have presented a legally sufficient evidentiary basis for the jury to determine the falsity of a particular claim.[42]

Despite the fact that, in addition to Dr. Liao's testimony, the government offered the testimony of the Patient Care Coordinator for AseraCare's Milwaukee branch, Roberta Manley, who testified that during IDG team meetings, the medical director in Milwaukee was "doing his drawings" and "wasn't participating,"[43] and that when the medical director missed a meeting, he would use a pre-signed MHB certification form,[44] the court held that the government never connected the behavior of the Milwaukee medical director

to Dr. Liao's expert review of the patients' records. The judge found that, of the small sample reviewed by Dr. Liao, only two patient records came from the Milwaukee branch, and the jury's verdict deemed only one of them false.[45] Moreover, the single false claim from Milwaukee upheld by the jury was for a patient who arrived at the hospice two-and-a-half years *after* Ms. Manley had left AseraCare.[46] Thus, said the court, "Ms. Manley's testimony does not explain why the opinions of the certifying doctors for [the patient in Milwaukee] lack reliability."[47] The court held that the government had therefore failed to establish a link between Ms. Manley's testimony and Dr. Steinberg's post hoc review of the claim submissions, and thus failed to prove that any one particular MHB-eligibility certification by an AseraCare physician could be considered a false certification.

Ultimately, in overturning the jury's verdict, the court expounded on its underlying concerns: "[A]llowing a mere difference of opinion among physicians alone to prove falsity would totally eradicate the clinical judgment required of the certifying physicians."[48] To allow such evidence to prove falsity, said the court, would mean that "hospice providers would be subject to potential FCA liability any time the Government could find a medical expert who disagreed with the certifying physician's clinical judgment."[49]

U.S. v. Vista Hospice

More recently, in *Vista Hospice*, the court cited the *AseraCare* decision and held that "[a] testifying physician's disagreement with a certifying physician's prediction of life expectancy is not enough to show falsity."[50]

In *Vista Hospice*, after the government declined to intervene, the qui tam relator moved forward on her fourth amended complaint, alleging that Vista falsely certified some of its patients as "terminally ill" and, thus, eligible for the MHB.[51] In support of the alleged falsity, the relator pointed to: (1) the opinion of her expert witness, Dr. Steinberg, that some of the patients in question were ineligible for the MHB; (2) evidence of a corporate "scheme" wherein the hospice provider allegedly admitted patients earlier than competitors before determining their eligibility, required layers of review before discharging patients, and instructed staff to document evidence supporting eligibility; and (3) "anecdotal evidence" from a few Vista employees that some information in certain patient charts had been falsified.[52]

Although the court determined that Dr. Steinberg's "subjective clinical analysis" was, by itself, "insufficient to prove certifying physicians erred in evaluating life expectancies," the relator argued that if viewed in conjunction with the evidence of Vista's corporate culture, a jury could infer that the claims submitted for the patients Dr. Steinberg reviewed were false.[53] Despite some evidence that Vista pressured employees to admit large numbers of hospice patents, and that some employees had falsified data on a few patient charts, the court concluded that the relator "has not tied that evidence to the patients whose charts Dr. Steinberg evaluated, nor to the submission of a single false claim."[54] In other words, "[w]ithout *any* evidence about the nurses and doctors involved in treating or certifying the sampled patients for hospice, for Relator to prevail at trial, jurors would have to take an impermissible inferential leap to conclude that those patients' certifications were not based on the proper clinical judgments of physicians."[55]

In response to the relator's argument that she was only required to show that Vista had operated with "reckless disregard" as to the falsity of its MHB eligibility certifications, and not that the claims were "actually false or fraudulent," the court held:

> This view reflects a misunderstanding of the FCA's falsity element, confusing the FCA's *scienter* requirement—which requires knowledge *or* reckless disregard— with the necessity to show that records or claims were *false*. The FCA's knowledge element is an independent, additional hurdle for Relator, not a shortcut around proof of falsity. Without evidence linking Relator's "scheme" evidence to the 291 patients whose files Dr. Steinberg analyzed, there is no evidence that the certifying physicians for the 291 patients were not exercising their best clinical judgments nor that they did not believe the subject patients were terminally ill when they certified them as such, and thus there is no evidence of the falsity required to establish liability.[56]

For these reasons, the court granted Vista's motion to strike the portion of Dr. Steinberg's testimony relating to the Vista physicians' subjective intent, and granted Vista's motion for summary judgment as to the false claims allegations.[57]

Conclusion

In an area of the law where very few cases reach actual litigation, resulting in very little case law to guide courts and litigants, the holdings in *AseraCare* and *Vista Hospice*—that contrary medical opinions cannot, without more, serve as the basis for an FCA claim—will likely serve as persuasive authority for future courts dealing with the issue of FCA falsity as it relates to MHB-eligibility determinations. Under this developing line of case law, in order to prevail in litigation, FCA plaintiffs will have to offer up more than just expert testimony disagreeing with the certifying provider's medical judgment. Instead, such expert evidence will have to be coupled with other evidence showing that the provider knew that the certifications were false and the plaintiff must be able connect that evidence to actual claims submitted for reimbursement.

1 *United States v. AseraCare Inc.*, No. 2:12-cv-245-KOB, 2016 WL 1270521 (N.D. Ala. Mar. 31, 2016).
2 *U.S. ex rel. Wall v. Vista Hospice Care, Inc.*, No. 3:07-cv-00604-M, 2016 WL 3449833 (N.D. Tex. June 20, 2016).
3 42 C.F.R. § 418.1 *et seq.* (2016).
4 42 U.S.C §§ 1395d(a)(4), 1395f (2015); 42 C.F.R. § 418.21; Ctrs. for Medicare & Medicaid Servs., CMS Pub. 100-02, Medicare Benefit Policy Manual, Ch. 9, § 10 (May 8, 2015), *available at* www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c09.pdf (last visited Sept. 30, 2016).
5 42 U.S.C. § 1395f (7)(A)(ii).
6 *Id.*
7 42 C.F.R. § 418.3.
8 An IDG must include: (1) a physician; (2) a registered nurse; (3) a social worker; and (4) a pastoral worker or other counselor. *Id.* § 418.56.
9 42 U.S.C. § 1395(a)(7)(A)(i). "Attending physician" means either a physician or appropriately-trained nurse practitioner whom the patient identifies, "at the time he or she elects to receive hospice care, as having the most significant role in the determination of the individual's medical care." 42 C.F.R. § 418.3.
10 Ctrs. for Medicare & Medicaid Servs., *SUPRA* NOTE 5.
11 42 C.F.R. § 418.22(a)(3)(i).
12 *Id.* § 418.22(a)(3)(ii)-(iii).
13 Medicare Program; FY 2014 Hospice Wage Index and Payment Update; Hospice Quality Reporting Requirements; and Updates on Payment Reform, 78 Fed. Reg. 48234, 48245–46 (Aug. 7, 2013).
14 *U.S. ex rel. Wall v. Vista Hospice Care, Inc.*, 2016 WL 344833, at *3 (citing 78 Fed. Reg. 48234, 48245).
15 42 C.F.R. § 418.102(b)(1)–(5).
16 *Id.* § 418.22(b)(2)–(3).
17 Ctrs. for Medicare & Medicaid Servs., *supra* note 5.
18 *Vista Hospice Care, Inc.*, 2016 WL 344833, at *3 (citing Ctrs. for Medicare & Medicaid Servs., CMS-Pub. 60AB, Program Memorandum Intermediaries/Carriers, Subject: Provider Education Article (Mar. 28, 2003)).
19 Ctrs. for Medicare & Medicaid Servs., *supra* note 5.
20 31 U.S.C. § 3729(a)(1)(A).
21 *See U.S. ex rel. Clausen v. Lab. Corp. of Am., Inc.*, 290 F.3d 1301, 1311 (11th Cir. 2002) (citing *Harrison v. Westinghouse Savannah River Co.*, 176 F.3d 776, 785 (4th Cir. 1999) ("The statute attaches liability, not to the underlying fraudulent activity or to the government's wrongful payment, but to the '*claim for payment*.' Therefore, a critical threshold question in [FCA] cases is whether the complaint adequately alleges that the defendant presented a 'false or fraudulent claim' to the government."); *see also*, *Urquilla-Diaz v. Kaplan Univ.*, 780 F.3d 1039, 1052 (11th Cir. 2015) ("[T]he '*sine qua non* of a False Claims Act violation' is the submission of a false claim to the government.") (citing *Corsello v. Lincare, Inc.*, 428 F.3d 1008, 1012 (11th Cir. 2005)).
22 Press Release, U.S. Dep't of Justice, *Orlando, Fla., Area Hospice to Pay $3 Million to Resolve Allegations That It Billed Medicare for Patients Not Terminally Ill* (Nov. 5, 2013), *available at* www.justice.gov/opa/pr/orlando-fla-area-hospice-pay-3-million-resolve-allegations-it-billed-medicare-patients-not.
23 *Id.*
24 *Id.*
25 *U.S. ex rel. Morton v. A Plus Benefits, Inc.*, 139 Fed. Appx. 980, 982 (10th Cir. 2005) (quoting *Wang v. FMC Corp.*, 975 F.2d 1412, 1421 (9th Cir. 1992)).
26 *Morton*, 139 Fed. Appx. at 983.
27 *E.g.*, *id.*; *see also*, *United States v. Prabhu*, 442 F. Supp. 2d 1008, 1026 (D. Nev. 2006) ("[C]laims are not 'false' under the FCA when reasonable persons can disagree regarding whether the service was properly billed to the Government.").
28 *See U.S. ex rel. Phillips v. Permian Residential Care Ctr.*, 386 F. Supp. 2d 879, 884 (W.D. Tex. 2005).
29 The FCA's knowledge standard includes actual knowledge, deliberate ignorance, or reckless disregard of the truth or falsity of the information. 31 U.S.C. § 3729(b)(1)(A)(i)-(iii).
30 United States' Consolidated Complaint in Intervention, *United States v. AseraCare, Inc.*, No. 2:12-cv-245-KOB, 2016 WL 1270521 (N.D. Ala. Mar. 31, 2016) (Nos. 2:12-cv-0245-KOB (LEAD), 2:12-cv-2264-KOB, 2:09-cv-0627-KOB), 2012 WL 5474885.
31 *Id.*
32 *Id.* ¶ 36.
33 *United States v. AseraCare Inc.*, 153 F. Supp. 3d 1372 (N.D. Ala. 2015).
34 *Id.* at 1376.
35 *United States v. AseraCare Inc.*, No. 2:12-cv-245-KOB, 2016 WL 1270521, at *2 (N.D. Ala. Mar. 31, 2016) (emphasis added).
36 *AseraCare*, 153 F. Supp. 3d at 1372.
37 *Id.* at 1375.
38 *Id.* at 1381 (emphasis in original).
39 *AseraCare*, 2016 WL 1270521, at *2.
40 *Id.* As of this publication, the government's appeal is currently pending before the Eleventh Circuit.
41 *AseraCare*, 153 F. Supp. 3d at 1381 (emphasis in original) (noting further that "Dr. Liao even acknowledged that he changed his opinion concerning the eligibility of certain patients from his 2010 review to his 2013 review").
42 *Id.* at 1377.
43 *Id.* at 1381.
44 *Id.*
45 *Id.*
46 *Id.*
47 *Id.*
48 *United States v. AseraCare Inc.*, No. 2:12-cv-245-KOB, 2016 WL 1270521, at *3 (N.D. Ala. Mar. 31, 2016).
49 *Id.*
50 *U.S. ex rel. Wall v. Vista Hospice Care, Inc.*, No. 3:07-cv-00604-M, 2016 WL 344833, at *17 (N.D. Tex. June 20, 2016).
51 *Id.* at *16.
52 *Id.* at *17.
53 *Id.* at *17–18.
54 *Id.* at *18.
55 *Id.* (emphasis in original).
56 *Id.*
57 *Id.* The court also granted, in part, Vista's motion to strike the testimony of the relator's expert statistician, Dr. Kriegler. Dr. Kriegler had created the sample of the 291 MHB claims reviewed by Dr. Steinberg, and had then extrapolated from Dr. Steinberg's analysis in order to opine on the total number of false MHB claims submitted by Vista. *Id.* at *12. Finding Dr. Kriegler's extrapolation evidence unpersuasive, the court ruled that it would not rely on or allow testimony based on Dr. Kriegler's conclusions. *Id.*

The Quality Assurance Privilege: Why It Exists, What It Protects, and How Health Care Providers Can Effectively Utilize It

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To improve quality of care and effect real change, health care providers must examine and evaluate the care they provide. Federal and state laws have recognized the need for such internal examination and have carved out privileges to keep these deliberations confidential. Courts have recognized that without confidentiality protections, health care providers may be deterred from performing comprehensive self-reviews for fear that such investigations could be used against them in litigation.[1] This article addresses the evolution of the quality assurance privilege, the current status of the law, and how health care providers can best protect against disclosure of these necessary and important self-critical evaluations.

Inception and Evolution of the Quality Assurance Privilege

The Federal Nursing Home Reform Act (FNHRA) was enacted in 1987 and was aimed at protecting the rights of nursing homes and similar facilities. The purpose of the FNHRA is to provide nursing home residents with services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.[2]

FNHRA requires nursing homes to maintain a quality assessment and assurance committee (QAA) to develop and implement plans to correct quality deficiencies.[3] The QAA committee must consist of the director of nursing services, a physician designated by the facility, and at least three other members of the facility's staff.[4] The QAA committee must meet at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary.[5]

In order to promote effective quality review, the FNHRA generally prohibits a state or the Department of Health and Human Services Secretary to require disclosure of the records of such committee.[6] The regulation implementing the QAA committee requirements mirrors the language set forth in the FNHRA.[7] Good faith attempts by the QAA committee to identify and correct quality deficiencies cannot be used as a basis for sanctions.[8] Further, a state or the Secretary may not require the disclosure of the records of the QAA committee unless such disclosure is related to the compliance of the QAA committee with the requirements of the regulation or the FNHRA.[9]

However, the regulation does not address whether the QAA committee's proceedings or documentation is privileged in the context of litigation. Courts have addressed this issue by carving out a quality assurance privilege to maintain confidentiality of certain documents relating to the QAA process. However, courts have not uniformly applied the privilege and have interpreted the intent of the FNHRA and implementation of the regulation differently.

While some courts have interpreted the regulation narrowly, other courts have granted broader protections to QAA committees and their documentation. For example, the Missouri Supreme Court limited the privilege to documents that are created and maintained by the QAA committee.[10] In contrast, the New York Court of Appeals provided broader protection for "any reports generated by or at the behest of a quality assurance committee for quality assurance purposes," including compilations, studies, or comparisons of clinical data created for such purposes.[11]

Although courts have interpreted the quality assurance privilege differently, there is general agreement that the privilege does exist. Courts have recognized that such a privilege is necessary to maintain high professional standards in the medical practice for the protection of patients and the general public. Because of the expertise and level of skill required in the practice of medicine, courts have found that the medical profession is in the best position to police its own activities.

Seminal Cases – "The Missouri Rule" and "The New York Rule"

Recognizing the Privilege – An Issue of First Impression

In 1997, the Missouri Supreme Court addressed an issue of first impression in the midst of a criminal investigation against a skilled nursing facility, commonly referred to as the *Boone* decision.[12] The Missouri Division of Aging conducted an investigation of a skilled nursing facility related to the development of in-house acquired pressure ulcers for a number of residents.[13] To conduct this investigation, the Attorney General subpoenaed certain records of the facility's "Quality Assurance Committee."[14]

Although the facility claimed that the requested documents were privileged pursuant to the FNHRA, the grand jury issued a subpoena duces tecum requiring the facility to produce "any and all quality assurance records, reports and/or attachments, reflecting materials generated by or presented to the facility's Quality Assurance Committee" for a two-year time period.[15] After its motion to quash this subpoena was overruled, the facility petitioned the Missouri Supreme Court.[16]

At the time of the Missouri Supreme Court hearing, the FNHRA statutes had not been interpreted by any court. Arguing that the statutes were clear on their face, the facility contended that records of a quality assurance committee were confidential and privileged pursuant to 42 U.S.C. § 1395i-3(b)(1)(B).[17] The court held that the FNHRA

protected "the committee's own records – its minutes or internal working papers or statements of conclusions,"[18] but did not extend the privilege to "records and materials generated or created outside the committee and submitted to the committee for its review."[19]

Expanding the Privilege—The Reach of the QAA Committee

The New York Court of Appeals adopted a more expansive view of quality assurance protection in 2003 which is often relied upon today and commonly referred to as the *Park Associates* decision.[20]

During a Medicaid fraud investigation into several nursing facilities, the Attorney General's office issued subpoenas seeking various documents and reports involving facility management and resident care and treatment.[21] The three nursing facilities argued that the subject reports and documents should be classified as records of the quality assurance committee under the FNHRA.[22]

The court distinguished the categories of documents for their review in two ways: (1) those documents created by a provider to comply with federal and state regulations which are "not expressly related to quality assurance" and (2) those documents created by or at the direction of a provider for quality assurance purposes.[23] Those documents whose primary purpose was linked to regulatory compliance and not quality assurance were discoverable.[24] Those documents **"generated by or at the behest of a quality assurance committee for quality assurance purposes"** were privileged under the FNHRA.[25]

While *Park Associates* clearly takes a more expansive view of the FNHRA than *Boone*, the cases are frequently cited together courts[26] and are affectionately credited with establishing "The Missouri Rule" and "The New York Rule."[27] These "rules" attracted the attention of providers and litigators, which ultimately led to further regulatory changes in the years to follow.

Quality Assurance Performance Improvement (QAPI)

The Affordable Care Act (ACA), which was passed in 2010, provides authority for the Centers for Medicare & Medicaid Services (CMS) to establish and implement a QAPI program for nursing facilities, including the development of standards relating to quality assurance and performance improvement.[28] As defined by CMS, QAPI is "the merger of two complementary approaches to quality management, Quality Assurance (QA) and Performance Improvement (PI)."[29]

The goal of this combined approach is to ensure "high quality care."[30] QAPI utilizes the QAA regulation and guidance and builds upon it.[31] It expands the level and scope of required activities to ensure that facilities identify and correct quality deficiencies and continuously improve quality of care.[32]

In 2012, CMS issued interim guidance for nursing facilities, *QAPI at a Glance*, which sets forth recommendations for developing and implementing QAPI programs. Many of CMS' recommendations center upon facilities using data to identify quality problems and opportunities for improvement and encourage comprehensive, self-critical analysis.[33]

To ensure that QAA and QAPI related documents and reports aimed at improving quality care are privileged as intended, providers should be aware of the requirements that have been established through regulations and case law and consider the "best practices" outlined below.

Best Practices for Asserting the Privilege

To achieve success in asserting the quality assurance privilege, providers must ensure that policies are in place from the outset which set forth the types of documents to be generated by or at the direction of the QAA committee. When establishing and updating a QAPI program, providers should consider the "five W's" below to ensure confidentiality of QAA committee records, reports, and documentation.

Who: Any review of quality indicators should be directed by the QAA committee. Reports or documentation detailing the QAA committee's findings should be authored by a member of the QAA committee. The QAA committee must consist of the Director of Nursing, a physician, and at least three other nursing staff members.

What: Ensure that reports and documents do not raise issues of compliance with regulations. Records of a QAA committee are not privileged if related to compliance of the QAA committee with the requirements of the regulations. Additionally, reports or documentation generated by the QAA committee should clearly state that the report is prepared for purposes of quality assurance.

Why: Merely marking a document "Quality Assurance" or "privileged" does not automatically provide protections. Instead, the substance of the documents must in fact analyze and evaluate quality of care. Staff should be trained accordingly.

When: Reports should be prepared as close in time to any incident as possible and prior to litigation or the threat of litigation. Reports prepared after the threat of litigation are discoverable.

Waiver: To avoid waiving the privilege, quality assurance discussions should be held within a formal committee and documents should be kept confidential. Importantly, sharing quality assurance documents with the Board of Directors does not operate as a waiver of the privilege and is encouraged by CMS.

Conclusion

While courts have recognized the importance of confidentiality in providers' systems to improve quality for their patients, health care providers should be aware that courts may maintain a narrow approach to the types of documents deemed privileged. For this reason, providers must be vigilant in establishing a QAPI program and guidelines for their QAA committees. Providers must ensure that the QAA committees are generating, or at a minimum directing, incident investigations and quality care reviews. These methods assist providers in maintaining the highly-coveted quality assurance privilege, which allows them to effectively look internally and assess their staff, leadership and systems, which results in quality care.

1 *See, e.g.*, *Katherine F. ex rel. Perez v. State,* 723 N.E.2d 1016 (N.Y. 1999).
2 42 U.S.C. § 1396r(b)(2) (2015).
3 *Id.* §§ 1396r(b)(1)(B), 1395i-3(b)(1)(B).
4 *Id.*
5 *Id.*
6 *Id.*
7 42 C.F.R. § 483.75(o) (2016).
8 *Id.* § 483.75(o)(4).
9 *Id.* § 483.75(o)(3).
10 *See, e.g.*, *State ex rel. Boone Ret. Ctr. v. Hamilton*, 946 S.W.2d 740, 743 (Mo. 1997).
11 *See In re Subpoena Duces Tecum to Jane Doe*, 787 N.E.2d 618, 623 (N.Y. 2003).
12 *See Boone Ret. Ctr.*, 946 S.W.2d at 742.
13 *Id.* at 741.
14 *Id.*
15 *Id.*
16 *Id.*
17 *Id.* at 742.
18 *Id.* at 743.
19 *Id.*
20 *See In re Subpoena Duces Tecum to Jane Doe*, 787 N.E.2d 618 (N.Y. 2003).
21 *Id.* at 619.
22 *Id.* at 619, 622.
23 *Id.* at 622–23.
24 *Id.* at 622.
25 *Id.* at 623.
26 *See, e.g.*, *Evans v. Quaboag on the Common, Inc.*, 26 Mass. L. Rptr. 372 (Mass. Super. Ct. 2009).
27 *See Richmond Health Facilities-Madison, LP v. Clouse*, 473 S.W.3d 79, 84 (Ky. 2015).
28 *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 6102, 124 Stat. 119, 704 (2010) (codified at 42 U.S.C. § 1320a-7j(c) (2015)).
29 *See* Ctrs. for Medicare & Medicaid Servs. et al., *QAPI at a Glance*, www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/qapiataglance.pdf (last visited Sept. 30, 2016) [hereinafter *QAPI at a Glance*].
30 *See id.*
31 *See id.*
32 *See QAPI*, CMS.gov, https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/nhqapi.html (last visited Sept. 30, 2016).
33 *See QAPI at a Glance*, *supra* note 29.

Financial Exploitation in Long Term Care Facilities

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A trusted and longstanding nursing facility business office manager was suspected of the unthinkable—stealing from resident trust fund accounts. Diligence by the home office had uncovered several red flags—unusual payroll entries, suspicious credit card transactions, and discrepancies with the cash receipts book. Meanwhile, certain resident family members were starting to ask why they had never received account statements.

Suddenly the pieces of the puzzle fell together—and the painful questions began: How long has this been going on? How did it happen? How much was stolen? What else has occurred? And especially: How did we not find it earlier?

The answers would not come quickly or easily—and the notifications to the state regulator, local law enforcement, and family members were sure to prompt more questions. The situation was a legal minefield—and if not handled appropriately, attention could shift from the suspect employee to the facility and corporate administration which were responsible for ensuring such fraud never happened in the first place.

The account described above, while fictional, is derived from case experience. It is important to remember that these issues can and do occur regularly at nursing facilities, large and small. This article discusses elder financial abuse in the nursing facility setting, offers advice gained from forensic casework on how to respond to resident trust fund embezzlement matters, and shares leading risk-mitigation practices.

Financial Exploitation: Definition and Legislative Background

Financial exploitation—the misuse or misappropriation, without explicit knowledge or consent, of the assets of a vulnerable person, for personal benefit—is a fast-growing form of senior abuse,[1] and one to which individuals with cognitive impairment (who make up a significant share of nursing facility residents overall) are especially vulnerable. According to the Department of Justice (DOJ), among national prevalence studies conducted in the United States, financial exploitation was either the most frequently or second most frequently self-reported form of elder maltreatment.[2] Yet such abuse is rarely reported to authorities.[3]

In 2010, the U.S. government enacted the bipartisan Elder Justice Act—the first comprehensive legislation to address elder abuse. Among its provisions, the Act authorized $125 million in federal funding to state and local Adult Protec-

tive Services (APS) programs (social services for seniors and adults with disabilities); provided support for a new "Long-Term Care Ombudsman Program" (advocates for nursing facility residents); and required the reporting of crimes in long term care facilities to law enforcement.

On March 30, 2016, DOJ further bolstered the protection of vulnerable seniors by announcing the launch of 10 regional Elder Justice Task Forces.[4] These teams bring together federal, state, and local prosecutors, law enforcement, and agencies that provide services to the elderly to coordinate and strengthen efforts to pursue nursing homes that provide substandard care to their residents.

The Resident Trust Fund: A Common Solution to a Common Problem

In addition to income from Social Security, retirement accounts and the like, residents of nursing facilities incur regular or occasional expenses for services received or purchases made at their behest. With advancing age or cognitive decline, many find themselves unable or unwilling to manage their personal finances on their own. Those who cannot—or choose not to—usually appoint a family member to handle this task. The family members in turn often seek assistance from the facility. Upon written request from the resident, nursing facilities are required to set up an interest-bearing account, separate from the institution's own funds, to manage the resident's money. These accounts are called *resident trust funds*.

An accounting system for a resident trust fund consists of: (1) an interest-bearing bank account; (2) individual resident participation files (an individual ledger showing all deposits and withdrawals involving the resident's funds); (3) a petty cash fund; and (4) receipt files. Facilities are required to keep a written record of the account activity, including the date, amount, and nature of the deposit or withdrawal—and, typically would retain receipts to document purchases of items or services. Disbursements should be approved via the resident's signature or, if she is unable to provide a signature, via two signatures of facility employees. Nursing facilities typically reconcile and review these accounts monthly and issue statements on a periodic basis.

Federal and state guidelines vary on how these resident trust funds should be managed and monitored. Many require nursing facilities to carry a surety bond for these accounts to protect residents in case their funds are misused.

Risks, Red Flags, and Regulators

In the real world of nursing facilities, business office managers—in carrying out their many administrative, non-patient care duties—typically wear several hats, one of which often includes managing the resident trust fund accounts. With typically lean administrative staffing, that manager is often the sole person in charge of every aspect of these accounts—handling bank deposits, disbursements, and cash transactions, preparing schedules of disbursement activity and required signatures, and compiling periodic account reconciliations.

Unfortunately, having key financial processes managed end-to-end by a single person, without oversight, violates one of the fundamental concepts of internal control—segregation of duties. It's easy to see how a combination of threadbare administrative staffing and poor internal controls can lead to mismanagement or outright fraud. And equally easy to grasp how such aberrations can go a long time without being discovered, if ever. Such activities may come to light only

when accidentally discovered—and subsequently reported—by a fellow employee.

This structural weakness puts more than residents' funds—and trust—at risk. It can gravely harm the facility's financial health, which rests on its reputation with its residents, their families, and the general public. It also puts the organization (including, if applicable, its corporate parent) at regulatory risk, at both the federal and local levels: all U.S. states, territories, and the District of Columbia have elder abuse laws on the books.[5]

The Department of Health and Human Services Office of Inspector General (OIG), in its Compliance Program Guidance for Nursing Facilities, has flagged the "failure to safeguard residents' financial affairs"—which includes resident trust fund theft—as a compliance risk area, stating that "[i]f misappropriation of a resident's property is uncovered, the facility administrator and other officials, in accordance with State law, must be notified immediately and an investigation conducted."[6]

You've Confirmed There Is an Issue: Now What?

After the initial shock of uncovering the matter, it is essential that facilities act quickly and decisively—under the direction of legal counsel—in responding to any suspicion of misappropriation of resident funds. Here are some guidelines learned from years of forensic work in this area:

1. *Restrict access.* While is not uncommon for an investigation to be triggered by the mere suspicion of impropriety, it is prudent to restrict the access of an employee under suspicion at the onset of the investigation. Such efforts could include disabling the employee's access to electronic information systems and instructing the employee to keep off the facility premises until further notification.

2. *Preserve the evidence.* When initiating the investigation, it is critical to swiftly secure and control access to potentially relevant electronic and paper records. For a resident trust fund investigation, this would include records such as resident trust fund reconciliations, disbursement logs, receipts, resident account statements, and bank statements. Electronic devices used by the suspect (such as a company-owned laptop or mobile device) should also be forensically preserved.

3. *Protect resident funds.* During the course of the investigation, a trusted individual should be designated to assume administration responsibilities over the resident trust fund system, and enhanced disbursement review and approval protocols should be implemented immediately. The nursing facility should also advance funds to affected residents during the investigation, as needed (*e.g.*, if a resident victim has no funds left in her account due to the suspected embezzlement and is temporarily unable to purchase needed goods or services).

4. *Conduct the investigation.* The heart of a forensic investigation is fact-gathering and analysis: the goal is to fully understand how the scheme was perpetrated, and by whom—and after punitive or enforcement action has been taken, to plug whatever holes led to the incident. Given the patchwork of federal, state and local regulations involved, it is essential that legal counsel provide direction in the investigation regarding scope, procedures, communication protocols, and applicable assertions of legal privileges. Fact-gathering occurs through interviews with facility employees and family members, as well as a review of facility records. Forensic financial analysis of resident trust fund activity should come next. This involves primarily (a) identifying (and later refunding) potentially unauthorized disbursements, and (b) identifying certain unauthorized disbursements that can be utilized by law enforcement.

5. *Unauthorized disbursements vs. inadequately documented ones.* When looking back on the books, it can be difficult to distinguish between fraudulent disbursements and ones that were simply inadequately documented. It is important to keep in mind that documentary deficiencies uncovered under financial analysis may not rise to the level of criminal conduct; rather these can be symptomatic of sometimes-less-than-rigorous bookkeeping practices conducted by employees with many other responsibilities. Under the heat of scrutiny, most facilities choose to err on the side of the resident and refund all disbursements that are not properly documented (even if the disbursement was likely appropriate) in order to avoid subsequent disputes with family members or regulatory agencies. However, law enforcement will be most interested in the type of evidence that can be utilized for prosecutorial purposes—such as unauthorized disbursements that appear not to have benefited the resident.

6. *Tread carefully with employees under suspicion.* A wild card that must be taken into account in the fraud investigation is the dynamic of dealing with the employee under suspicion. In many instances, the dishonest business office manager will deny the allegation when confronted, flee the premises, and not return. She may also attempt to control the narrative and interfere with the investigation

by, for example, communicating with other facility employees or with family members of facility residents. Witness statements of such conduct can be helpful during the prosecution of such cases.

7. *Notifications and reporting.* One early question in an investigation is "Who should be notified?" First, make sure the appropriate administrative personnel are aware of the matter—this can include the facility director and corporate personnel in functions such as Legal, Compliance, Internal Audit, and Human Resources. Second, confer with Legal regarding notifications to law enforcement and regulatory authorities. While reporting requirements vary by state, this group would likely include APS, local and/or federal law enforcement, prosecutors, regulators, licensing agencies, and Medicaid Fraud Control Units. In addition to state mandatory reporting laws, federal law requires long term care facilities that receive at least $10,000 in federal funds during the preceding year to report suspected crimes against a resident to state agencies and to local law enforcement.[7] Such external notifications play an important role in aligning the facility's investigation activities with the expectations of law enforcement and regulatory agencies.

8. *Fallout and follow-up.* Be prepared to defend your decisions about the scope and shape of the investigation to both skeptical family members and regulators. It is also important to be cognizant of the investigation challenges that accompany embezzlement matters: when someone has intentionally concealed misconduct and misrepresented books and records, certain historical documentation practices may no longer be perceived as reliable. When the suspect employee has been in her position for a lengthy period of time, the financial toll of a long-running embezzlement can be significant. Unfortunately, since individuals who steal money from resident trust accounts may also use other means to enrich themselves, it is prudent to examine other business processes at risk as well—such as the corporate credit card, payroll system entries, and the handling of cash receipts at the facility. It can also be worthwhile to revisit that employee's background to determine if the behavior predated employment at the facility.

Risk Mitigation: An Ounce of Prevention

As we have seen, governance of resident trust funds can be a delicate task, and one that is fraught with risk. Leading practices that facilities may consider when looking to improve their processes and mitigate some of that risk include:

- *Transparency with resident trust account statements.* Embezzlement can thrive where visibility is low. Dishonest business office managers have often helped cover their crimes by withholding resident trust account statements from family members. Therefore, consider (1) using a statement distribution process that does not involve the employee responsible for the resident trust account, and (2) requesting that family members return a signed copy of the statement in order to evidence their review. Clearly, residents without involved family members are at greatest risk for financial elder abuse. In situations where the business office manager is the only individual aware of the resident's trust account activity, it is wise to have the facility director or a home-office employee review the resident trust account statements.
- *Disbursement authorization and receipt documentation.* Although a facility may have a process that requires a resident's authorization for all disbursements, it is not uncommon for a dishonest business office manager to forge signatures on a disbursement log. Again, where there are no involved family members to check statements, facilities should consider utilizing a second reviewer to examine disbursement logs with an arm's-length skepticism.
- *Data analytics.* Multi-location nursing facility companies typically use software to manage the resident trust account process across all locations. These companies should consider using data analytics to identify potential red flags when comparing individual facility metrics—such as frequency of round-dollar disbursements by size and volume of disbursement dollars. This information can be utilized by the corporate parent to plan targeted reviews of unusual disbursement activity across the enterprise.
- *Background checks.* It is not uncommon for unscrupulous business office managers to move from one facility to another to commit their crimes. Nursing facilities should utilize a background check process to screen potential employees for positions of trust (such as a business office manager), and re-perform background checks on a periodic basis for employees who are promoted to positions of trust at the facility.

Conclusion

U.S. nursing homes—with over 1.4 million residents as of December 31, 2014[8]—play a critical role in protecting the elderly from financial exploitation. But occasionally nursing

facilities, like any other kind of organization, unknowingly harbor personnel who would abuse the trust placed in them.

Elder financial abuse in a nursing facility setting is an especially abhorrent violation of trust—and it can and does occur even in facilities that follow some of the oversight procedures and background checks recommended here. When these breakdowns take place, the mandatory reporting requirements can result in a "second set of eyes" (e.g., from adult protective services, the state licensing agency, and law enforcement) that can monitor and critique the nursing facility's response to employee embezzlement. Hopefully this greater degree of scrutiny can lead in turn to more comprehensive risk mitigation for the organization—so that no elderly resident suffers again the fate of losing her assets at the most vulnerable time of her life.

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1 Nat'l Adult Prot. Servs. Ass'n, *Elder Financial Exploitation*, www.napsa-now.org/policy-advocacy/exploitation/ (last visited Sept. 26, 2016).
2 U.S. Dep't of Justice, *Elder Justice Initiative: Financial Exploitation FAQs*.
3 *Id.*
4 U.S. Dep't of Justice Press Release, *Department of Justice Launches 10 Regional Elder Justice Task Forces* (Mar. 30, 2016), *available at* www.justice.gov/opa/pr/department-justice-launches-10-regional-elder-justice-task-forces.
5 These laws vary by state. A complete list of state-by-state resources can be found at the National Center on Elder Abuse website. *See State Resources*, Nat'l Ctr. on Elder Abuse, https://ncea.acl.gov/resources/state.html (last visited Sept. 26, 2016).
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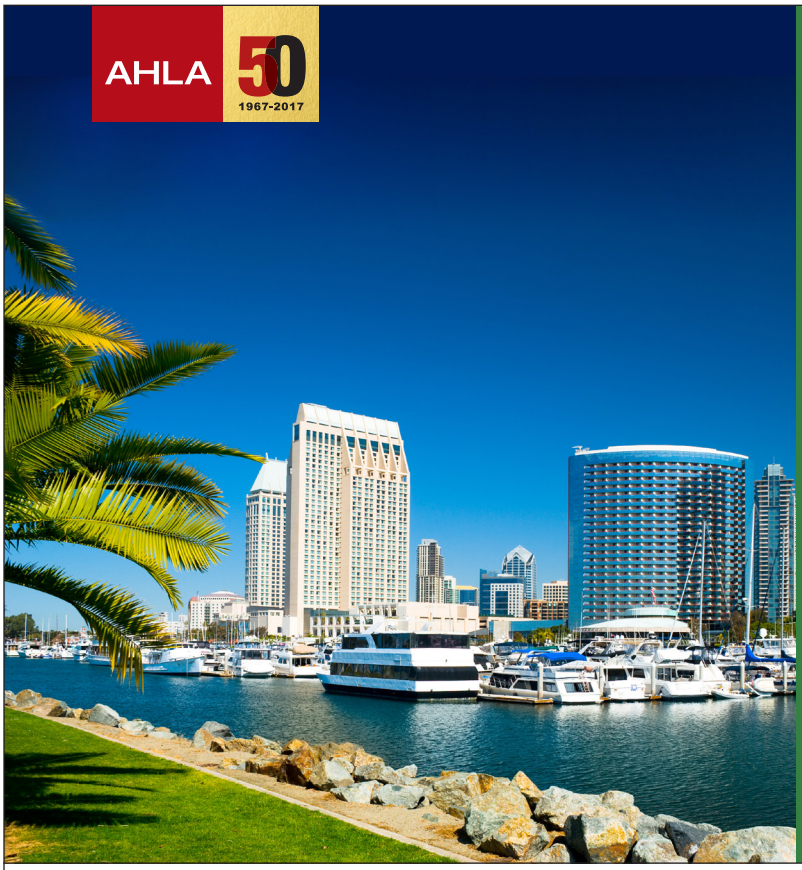

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