vermont psychiatric survivors

Equal Rights, Protection and Participation

September 10, 2017

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Department of Mental
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Waterbury, VT 05671-2010

Melissa Bailey, Commissioner
Department of Mental Health
280 State Drive, NOB 2 North
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Mourning Fox, Deputy Commission
Department of Mental Health
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Re: *Limitations on Hospital Refusal of Patients*

Dear Attorney Barber, Commissioner Bailey and Deputy Commissioner Fox:

At the August 17, 2017, public hearing on Act 82, Deputy Commissioner Fox stated in response to an attendee's question that psychiatric hospitals could refuse a patient for any reason. I took issue with his response, and in fact strongly disagree with that statement. In separate emails, each of you essentially asked me the basis of my disagreement.

Due to the press of professional and personal business, I have not been able to respond as timely as I would have liked. While I still do not have the time to give you my in-depth analysis of the issue, I would like to share with you some of the information on which my disagreement with Deputy Commissioner Fox is based.

The Emergency Medical Treatment and Labor Act (EMTALA) requires that a participating hospital with an emergency department (ED) must provide, upon request, an appropriate medical screening examination, within the capability of the hospital's ED, to determine whether an emergency medical condition exists, as defined in section 1867

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(e)(1) of the Act. (42 U.S.C. § 1395dd.) If an individual has an emergency medical condition, the hospital must provide, within the capabilities of the staff and facilities available at the hospital, treatment to stabilize the condition, unless a physician certifies that the individual should be transferred because the benefits of medical treatment elsewhere outweigh the risks associated with transfer. If a transfer is ordered, section 1867(c) of the Act requires the transferring hospital provide stabilizing treatment to minimize the risks of transfer. ***A receiving hospital that has specialized capabilities may not refuse to accept an appropriate transfer of a patient who requires such capabilities. (42 U.S.C. § 1395dd(g).)***

Hospitals must accept transfers even if they do not have an emergency department. (42 CFR 489.24(f); see also, Centers for Medicare and Medicaid Services, Medicare State Operations Manual, Appendix V, Interpretive Guidelines, Responsibilities of Medicare Participating Hospitals in Emergency Cases, Tag A-2411, C-2411, Rev. 60 (2010) .)

In two cases of which I am aware, such hospitals were fined for refusing to accept the transfer of patients suffering from psychiatric emergencies. (University Hospital paid $180,000 for refusing to accept five psychiatric patient transfers and Behavioral Health Hospital (Lutcher, Louisiana, formerly known as St. James Hospital) was fined $30,000 by CMS for refusing to accept the transfer of two psychiatric patients.)

I also direct your attention to limitations on refusals to treat justice-involved individuals. Please see CMS, Updated Guidance to Surveyors on Federal Requirements for Providing Services to Justice Involved Individuals, Dec. 23, 2016, p. 8. I am including a copy of the document with this letter.

I am also including with this letter a copy of the settlement agreement between the United States Department of Health and Human Services and AnMed Health. In that case, AnMed Health agreed to pay the Office of Inspector General $1,295,000, to settle allegations that in 2012 and 2013 it held patients with unstable psychiatric conditions in its emergency department without providing appropriate psychiatric treatment in 36 incidents.

"Instead of being examined and treated by on-call psychiatrists, patients were involuntarily committed, treated by ED physicians and kept in AnMed's ED for days or weeks instead of being admitted to AnMed's psychiatric unit for stabilizing treatment," according to the settlement agreement.

The patients — most of whom were suicidal and/or homicidal and suffered from serious mental illness — were held in the ED from six to 38 days. In each of these incidents, AnMed had on-call psychiatrists and beds available in its psychiatric unit to evaluate and

stabilize the patients. But it but did not provide examination or treatment by a psychiatrist, according to the settlement agreement.

Finally, I would generally refer you to the EMTALA "reverse dumping" guidance letters from the Office of Inspector General.

In short, I think EMTALA and the regulations and guidance letters interpreting it provide ample evidence that there are limitations on a Medicare-participating hospital's ability to refuse to provide inpatient psychiatric care to patients requiring such care.

Thank you for your interest in this issue.

Very truly yours,

Wilda L. White

Enclosures as stated

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**Center for Clinical Standards and Quality/Survey & Certification Group**

**Ref: S&C: 16-21-ALL**
**REVISED: 12.23.2016**

**DATE:** **May 03, 2016**

**TO:** State Survey Agency Directors

**FROM:** Director
Survey and Certification Group

**SUBJECT:** *Updated* Guidance to Surveyors on Federal Requirements for Providing Services to Justice Involved Individuals

****Revised to remove the requirements for, and all references to, hospital specialty units to ensure that hospitals are able to meet the unique security needs for justice involved individuals receiving treatment ****

**Memorandum Summary**

- **Surveyor Guidance:** The Centers for Medicare & Medicaid Services (CMS) are clarifying requirements for providing services to justice involved individuals in skilled nursing facilities (SNFs), nursing facilities (NFs), and intermediate care facilities for individuals with intellectual disabilities (ICFs/IID). Specifically, this guidance seeks to assure high quality care that is consistent with essential patient rights and safety for all individuals.
- *This policy memorandum replaces S&C: 16-21-ALL published May 03, 2016.*

## A. Introduction

Many States are examining the role that the health care system plays in providing vital services to individuals during and following a period of incarceration. For example, some individuals were previously uninsured and may have long-untreated health conditions. Others have aged in prison and may be discharged under compassionate release policies or may need specialized care for chronic or debilitating conditions.

In particular, States are considering the role that Medicaid can play in facilitating better access to health care for individuals prior to, during, and after, a stay in a correctional facility. The Social Security Act (the Act) prohibits federal financial participation (FFP) under Medicaid for inmates of a public institution, but provides an exception to this exclusion for patients in a medical institution[1]. The CMS Center for Medicaid and Children's Health Insurance Program (CHIP)

[1] Section 1905(a)(29)(A) of the Act prohibits Medicaid federal financial participation (FFP) for "any such payments with respect to care or services for any individual who is an inmate of a public institution (*except as a patient in a medical institution*)" [Emphasis added].

Services (CMCS) recently issued a letter to State Health Officials (SHO) that clarifies the definition of inmate of a public institution for purposes of Medicaid eligibility and to whom this exception applies. The letter is available at: https://www.medicaid.gov/federal-policy-guidance/downloads/sho16007.pdf. Additionally, Medicare has requirements and payment limitations that would also apply.[2]

Generally, three questions are particularly pertinent to this topic:

1. ***Individual*** - Does the individual meet the inmate exception or otherwise qualify for medical services? The SHO letter explains, for example, that an individual's eligibility for Medicaid may be established during incarceration even though no FFP may be available due to their inmate status. Enrolling the individual during the period of incarceration may facilitate his or her reentry by enabling timely access to needed health services upon the individual's release from prison.[3]
2. ***Service*** – Is the service covered by Medicare or under the State's Medicaid plan, and does the individual qualify for the medical service (e.g., by virtue of assessed need and medical judgment)?
3. ***Provider*** – Does the provider of services qualify for payment by virtue of having a Medicare or Medicaid provider agreement, and maintain continuous compliance with Medicare and Medicaid Requirements for Participation (Requirements) or Conditions of Participation (CoPs)?

This memorandum addresses only the third topic – certified provider compliance with Medicare and Medicaid participation requirements.

In this memorandum, the umbrella term "justice involved individuals" includes the following three categories of individuals:

**Inmates of a public institution:** Individuals currently in custody and held involuntarily through operation of law enforcement authorities in an institution which is the responsibility of a governmental unit or over which a governmental unit exercises administrative control, such as ~~a~~ state or federal prisons, local jails, detention facilities, or other penal settings (e.g., boot camps, wilderness camps).

**Individuals under the care of law enforcement**: Individuals who have been taken into custody by law enforcement. Law enforcement includes local and state police, sheriffs, federal law enforcement agents, and other deputies charged with enforcing the law.

**Individuals under community supervisio**n. Individuals who are on parole, on probation, or required as an alternative to criminal prosecution by a court of law to conditions of ongoing supervision and treatment.

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[2] This issue is described more fully in the Medicare Learning Network Publication: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Items-Services-Furnished-to-Beneficiaries-in-Custody-Under-Penal-Authority-Fact-Sheet-ICN908084.pdf

[3] The SHO letter also clarifies that individuals serving part of their sentence in halfway houses may not be subject to the payment exclusion if certain conditions apply and that individuals under community supervision are not subject to the payment exclusion. It is important to note that CMS does not certify or survey halfway houses.

**B. Medical Institutions - Provider Requirements**

To be eligible to receive Medicare or Medicaid payment, medical institutions must demonstrate continuous compliance with federal requirements. Providers and certain certified suppliers must be certified for participation in Medicare or Medicaid and are subject to periodic, onsite recertification surveys (inspections) to assess their continued compliance, as well as to investigations that focus on particular areas that may be the subject of a complaint received by CMS or by a State Survey Agency (SA).[4]

Medicare and Medicaid CoP requirements are different for different types of providers. For example generally:

- ***Hospitals:*** The CoPs focus on acute care needs of inpatients and outpatients, and recognize that there can be a very large array of situations that may be presented for treatment.

- ***Psychiatric Hospitals:*** Psychiatric hospitals are subject to the same CoPs as other hospitals, except the medical record services requirement specified at 42 C.F.R. §482.24, plus two additional CoPs that focus on the unique care needs of psychiatric patients.

- ***Critical Access Hospitals (CAHs):*** The CoPs specific to CAHs focus on short stay, acute care needs of inpatients and outpatients, and take into account that there is a wide array of treatment situations. However, CAHs are different Medicare/Medicaid providers than hospitals, and except for CAH psychiatric and rehabilitation units, are subject to a different set of CoPs than hospitals.

- ***Nursing Homes (NHs)*** – The Requirements for Long Term Care Facilities (Requirements for Participation) accommodate both short and long-range needs, with a primary focus on the fact that the nursing home often serves as the individual's residence. Resident rights, choices, and dignity are therefore important features of the statutory and regulatory requirements. The requirements for nursing homes are the same for Medicare[5] and Medicaid.[6] The Medicaid nursing home benefit may also include levels of care in addition to the skilled nursing home care that is covered in Medicare. Individuals may be admitted as a resident of a nursing home only if they meet certain level-of-care and screening requirements, such as preadmission screening and resident review (PASRR).[7]

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[4] CMS may also deem an accreditation of a provider to be sufficient as demonstrating compliance with the CoPs, if that accreditation is conducted by a CMS-approved accrediting organization. Deemed providers remain subject to complaint investigations conducted by CMS or SAs, as well as full validation surveys that are conducted by CMS or SAs to check on the adequacy of the accrediting organization's surveys.

[5] Sections 1819(a), (b), (c) and (d) of the Act and 42 CFR Part 483, Subpart B.

[6] Sections 1919(a), (b), (c) and (d) of the Act and 42 CFR Part 483, Subpart B.

[7] PASRR is an important tool for states to use in rebalancing services away from institutions and towards supporting people in their homes, and to comply with the Supreme Court decision, *Olmstead vs L.C.*, 527 U.S. 581 (1999), which held that, under the Americans with Disabilities Act, individuals with disabilities cannot be required to be institutionalized to receive public benefits that could be furnished in community-based settings. PASRR can also advance person-centered care planning by assuring that psychological, psychiatric, and functional needs are considered along with personal goals and preferences in planning long term care. The PASRR process requires that all applicants to Medicaid-certified Nursing Facilities be given a preliminary assessment to determine whether they *might* have mental illness or intellectual disability. This is called a "Level I screen." Those individuals

- ***Intermediate Care Facilities for Individuals with Intellectual Disabilities*** **(*ICFs/IID)*** – Like nursing homes, ICFs/IID must pay particular attention to resident rights, choices, and dignity. They must ensure that only individuals who need and receive active treatment are admitted.

The needs of justice involved individuals may be accommodated in the varying types of medical institutions. However careful attention needs to be paid so that these needs are met in a manner consistent with federal requirements. In some cases, institutions have been able to demonstrate compliance with federal requirements. In other situations, they have not been able to do so (in which case, depending on State law, they usually functioned under State licensure without Medicare or Medicaid payments). The provider's ability to meet these needs and remain in compliance with federal requirements depends in large part on the interaction between (a) the nature of the individual's needs, behaviors, and restrictions, (b) the manner in which those needs or restrictions are addressed in the facility, and (c) capabilities of the relevant institution.

## C. Questions Applicable to all Provider Types

A health care institution that provides care and services to justice involved individuals must be surveyed with the federal requirements applicable to all other health care institutions in the same provider type category.

Because Medicare and Medicaid requirements vary by provider type, we cover each provider or certified supplier separately. Any institution/facility that is regulated by Federal CoPs or Requirements for Participation in Medicare and Medicaid must adhere to those conditions or requirements and administer them in a manner that does not violate any individual's rights. However, there are key questions surveyors must ask in all settings. These include:

- ***Governance:*** Does the provider or the Department of Corrections (DOC)/Parole Board maintain control over the conditions under which the individual receives care? It would not be permissible for the DOC or Parole Board to maintain control over the conditions.
- ***Screening, Admission, Discharge***: Are federal requirements for screening and emergency care met, when applicable, e.g., the Emergency Medical Treatment and Labor Act (EMTALA)? Are federal requirements for admission and discharge processes met? Does the institution maintain admission processes to ensure that individuals are qualified for admission and that the institution/facility is capable of providing the necessary care? Institutions should receive sufficient information prior to admission of any patient or resident (e.g., medical records, diagnoses, etc.). Do individuals with a mental health diagnosis receive proper screening for mental health services under the preadmission

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who test positive at Level I are then evaluated in depth, called "Level II" PASRR. The results of this evaluation result in a determination of need, determination of appropriate setting, and a set of recommendations for services to inform the individual's plan of care. Regulations governing PASRR are found in the Code of Federal Regulations, primarily at 42 CFR Part 483, Subpart C. See: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Institutional-Care/Preadmission-Screening-and-Resident-Review-PASRR.html

screening and resident review (PASRR) requirements? PASRR is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care. PASRR requires that 1) all applicants to a Medicaid-certified nursing facility be evaluated for mental illness and/or intellectual disability; 2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings); and 3) receive the services they need in those settings.[8]

- ***Assessment of Individual Need for Care and Treatment:*** Do the medical professionals at the institution or facility gather information and work in concert with other medical professionals and caregivers who have knowledge of the individual and his or her needs? Does the institution maintain processes to ensure that individuals are adequately assessed with respect to their needs for care and treatment, and are provided care that directly corresponds to their needs?

- ***Treatment***: Do the services, treatment and restrictions applied by the medical institution for the patient or resident:

    a. Derive directly and exclusively from the patient/resident assessment(s) conducted by the facility's medical professionals?
    b. Flow directly from the prescriptions and treatment plan authored by the individual's physician and provider's medical professionals who are responsible for the care of the person in the facility (versus being imposed by outside authorities unsupported by independent assessment and judgment of the practitioners who are responsible for the person's care in the certified institution)?
    c. Adequately provide the federally-required level of care and services, and meet the needs of the individual within the capability of the medical institution? For example, do individuals in the ICF/IID or psychiatric hospital need and receive active treatment?

- ***Role:*** Does the institution/facility administer or provide treatment or restrictions that do not flow from the independent, clinical judgment of medical professionals responsible for the care of the individual in the certified institution? Is the medical institution in the position of serving as an agent of the correctional or law enforcement authority?

- ***Staffing and Training:*** Does the institution/facility have sufficient numbers and types of staff with specific training on how to provide care to an individual subject to the jurisdiction of a law enforcement or correctional agency (e.g., maintaining professional boundaries, not sharing personal information, and ensuring a safe environment)?

- ***Protections and Care for All***: Does the institution/facility meet the needs of all patients or residents, and maintain staffing, staff training and qualifications, equipment, and other

[8] *Ibid.*

capabilities to ensure that safety, rights and quality of care are maintained for all patients or residents? Does the institution/facility promote and protect patient and resident rights?

These are the same questions that surveyors must ask in relationship to the treatment of all patients or residents, but because of the nature of criminal justice supervision, it is at times more challenging to accommodate the supervision requirements expected by supervising authorities and still comply with CoPs, Requirements for Participation and other CMS requirements.

We hope that this communication will aid surveyors and providers in identifying some of the important questions and considerations that should be posed in a survey, as well as serving as a resource for medical institutions to aid in their maintaining compliance with Medicare and Medicaid provider and certified supplier requirements. Therefore, in the remainder of this guidance we focus on the federal requirements for Medicare and Medicaid participation, rather than on the legal status of an individual.

## D. Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs)

For Medicare or Medicaid to pay for care in a SNF or NF, the residents must meet Medicare or Medicaid eligibility requirements related to the level of care required in that setting (which establish the medical necessity of the services). Regardless of payor source, the nursing home must assess all individuals' needs, and must be able to maintain compliance with the Requirements for Participation for all residents (which means offering the same rights, protections, and individualized care and services). The SNF or NF should not accept any individual where the nursing home determines that it cannot appropriately meet that individual's needs and simultaneously protect the health, safety, and rights of other individuals (e.g., other residents, staff, and visitors).

Nursing homes should work in conjunction with correctional providers to ensure that the individual's medical records and other pertinent information are available to the nursing home that is admitting the individual.

It is possible that some DOCs or law enforcement's terms of supervision may conflict with CMS requirements, if those terms affect the care and services being provided in the nursing home or if the nursing home is violating an individual's rights by enforcing the terms directly. Under federal requirements, a nursing home cannot incorporate into care plans restrictions that violate resident rights, and cannot serve as an agent of the pertinent law enforcement or criminal justice supervisory authority by enforcing supervisory conditions or reporting violations of those conditions to officials. Additionally, there can be no integration of the criminal justice supervisory function into the essential operations or physical environment of the nursing home, such as parole officers attending inpatient care planning meetings or the DOC maintaining an office within the nursing home.

### *Resident Rights*

SNFs and NFs, as residential environments, must permit residents to have autonomy and choice, to the maximum extent practicable regarding how they wish to live their everyday lives and receive care. Federal statutes and regulations establish an array of individual rights and

safeguards. Nursing homes cannot impose conditions or restrictions that undermine resident rights and protections required by federal law. Facilities cannot require prospective residents to give up their rights as a requirement for admission. Resident rights in the nursing home include, but are not limited to the right to:

- Be free from physical or chemical restraints imposed for discipline or convenience, and not for treatment of a resident's medical condition;[9]
- Choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care [and] interact with members of the community both inside and outside the facility;[10]
- Personal privacy and confidentiality of his or her personal and clinical records;[11]
- Immediate access to any resident by the following: subject to the resident's right to deny or withdraw consent at any time, immediate family or other relatives of the resident; and subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, others who are visiting with the consent of the resident;[12]
- Be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.[13]

Also, nursing home residents must not only be able to exercise their rights as residents of the facility and as citizens of the United States, but also have the right to be free of interference, coercion, discrimination, or reprisal from the facility in exercising those rights.[14]

***Facility Policies and Practices***

Some DOC or law enforcement terms of release or placement may conflict with the CMS requirements if the terms affect the care and services provided by the facility or violate the resident's rights. In such a case, if a facility agreed to enforce restrictive law enforcement terms applied to a resident (for example, restricting visitors), the nursing home would not be in compliance with federal requirements and would risk enforcement action and termination from participation if it did so.

The facility may not establish policies or impose conditions on the resident that result in restrictions which violate federal law and regulation outlined in 42 CFR Part 483, Subpart B. The facility must promote care for its residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Examples of prohibited facility restrictions include, but are not limited to:

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[9] Section 1819(c)(1)(A)(ii) of the Act~~,~~ and 42 CFR §483.13(a).
[10] Section 1819(c)(1)(A)(viii) of the Act and 42 CFR §483.15(b)(1) and (2).
[11] Section 1819(c)(1)(A)(iv) of the Act and 42 CFR §483.10(e).
[12] Section 1819(c)(3)(B) and (C) of the Act and 42 CFR §483.10(j)(vii) and (viii).
[13] Section 1819(c)(1)(A)(ii) of the Act and 42 CFR §483.13(b).
[14] Section 1819(c)(1) of the Act and 42 CFR §483.10(a)(1).

- The facility makes a determination as to which visitors a resident may or may not see. The resident has the right to choose his or her own visitors;[15]
- The facility requires or implements a DOC or law enforcement restriction that the individual must reside in a locked unit in the SNF or NF for reasons that are not derived directly and exclusively from the resident's assessment(s) as conducted by the facility's medical professionals;[16]
- The facility does not allow a resident to possess a personal telephone and/or denies a resident the right to conduct telephone conversations in private;[17] or,
- The facility has a requirement that a resident must wear an item (e.g., a color-coded bracelet) that indicates to staff that they are justice involved.[18]

## E. Hospitals (Including Psychiatric)

In accordance with the requirements of the EMTALA[19], Medicare-participating hospitals that have dedicated emergency departments (DEDs) and/or specialized capabilities have certain obligations to individuals that apply to everyone including justice involved individuals. Note that CAHs are required to provide emergency services on a 24-hour day basis and, as a result, all CAHs are subject to the EMTALA requirements.[20] In the case of hospitals with DEDs and CAHs, they must provide an appropriate medical screening examination and when applicable, stabilizing treatment to any individual who comes to the emergency department, including justice involved individuals.

Hospitals with specialized capabilities must accept appropriate transfers from the DED of another hospital or from a CAH of any individual who requires specialized treatment capabilities, unless the receiving hospital lacks capacity to accept the transfer. Again, the law makes no distinction with respect to justice involved individuals. Therefore, hospitals subject to EMTALA, including all CAHs, do not have the option of refusing to provide services required under EMTALA to justice involved individuals.

Medicare/Medicaid participating hospitals are not criminal justice or law enforcement institutions and cannot maintain the custody of an individual for law enforcement. In order to maintain custody of the individual, the law enforcement personnel must be physically present with the individual at all times.

### *Therapeutic Interventions involving the use of Restraint or Seclusion:*

The CoPs for hospitals, which also apply to distinct part units in CAHs and psychiatric hospitals, provide that all patients have the right to be free from restraint or seclusion, but permit restraint or seclusion that is "imposed to ensure the immediate physical safety of the patient, a staff member, or others, but must be discontinued at the earliest possible time" (42 CFR § 482.13(e)). Such use of restraints or seclusion in a hospital is also subject to a variety of safeguards. For

[15] Section 1819(c)(3) of the Act and 42 CFR § 483.10(j)(1)
[16] 42 CFR § 483.13(a) and (b)
[17] 42 CFR § 483.10(k) and (l)
[18] 42 CFR § 483.15(a) and (b)(3).
[19] Section 1867 of the Act, and 42 CFR §§ 489.20(m), (q) and (r) and 489.24.
[20] Section 1866(a)(1)(I) and (a)(1)(N) of the Act .

example, restraints may only be used in accordance with a physician's order (or order of another licensed practitioner) after less restrictive methods have been determined to be ineffective (42 CFR § 482.13(e)).

When restraint or seclusion is used to manage violent or self-destructive patient behavior, there are further safeguards that apply. For example, when an adult patient is restrained or placed in seclusion by hospital personnel to manage violent or self-destructive behavior, the order must be reviewed at least every four hours and is renewable only up to 24 hours (42 CFR § 482.13(e)(8)). At that time a physician responsible for the care of the patient must see the patient and assess the need for continued restraint before another order for restraint or seclusion to manage violent or self-destructive behavior may be written.[21]

A justice involved individual who has been brought to the hospital for diagnosis or treatment and who simultaneously remains in the custody of the DOC or law enforcement personnel, may be subject to security measures imposed by such personnel, such as physical restraints. In order to maintain custody of the individual, the DOC/ law enforcement personnel must be physically present with the individual at all times. When enforcement personnel impose security measures, such as the use of restraint, those security measures are not governed by the CoPs, as long as the hospital does not participate in such measures. (It should be noted, however, that any request by the hospital to enforcement personnel to apply restraint to a patient in the DOC/law enforcement's custody would be considered use of restraint by the hospital, and if enforcement personnel comply with the hospital's request, then the hospital would be subject to the CoPs).

Note security personnel who are under contract with the hospital represent an extension of hospital staff. These individuals must be appropriately trained and supervised and are subject to the standards applicable under the Conditions of Participation.

Regarding the use of restraints on a justice involved individual in a hospital setting (rather than the use of restraints by health care personnel), the CMS State Operations Manual (SOM), Appendix A states the following:

> *The use of handcuffs, manacles, shackles, other chain-type restraint devices, or other restrictive devices applied by non-hospital employed or contracted law enforcement officials for custody, detention, and public safety reasons are not governed by this rule. The use of such devices are considered law enforcement restraint devices and would not be considered safe, appropriate health care restraint interventions for use by hospital staff to restrain patients. The law enforcement officers who maintain custody and direct supervision of their prisoner (the hospital's patient) are responsible for the use, application, and monitoring of these restrictive devices in accordance with Federal and State law. However, the hospital is still responsible for an appropriate patient assessment and the provision of safe, appropriate care to its patient (the law enforcement officer's prisoner).*[22]

[21] See 42 CFR §§ 482.13(e) and (f) and Tags A-0154 through A-0208 in Appendix A of the State Operations Manual (SOM) (Internet Only Manual, Pub. 100-07) for more details.
[22] Tag 0154, Appendix A of the SOM.

Even when restraints are applied in the hospital setting by law enforcement, the hospital is responsible for affording the patient his/her rights under the CoPs. These include the right to file a grievance,[23] participate in the development and implementation of the care plan,[24] make informed decisions regarding care,[25] and confidentiality of clinical records.[26]

***Law Enforcement-related Medical Interventions***

If the medical intervention is performed for law enforcement purposes rather than to provide diagnosis or treatment of the patient, then the intervention would not be viewed as a health care service. If, for example, hospital staff perform a test or an examination without clinical justification, to determine if an individual has concealed items within a body cavity, or to confirm ingestion or placement of an item, the staff would not be providing care to meet the health needs of the patient. In such a situation, the hospital must ensure that there is a lawful order by a court with appropriate jurisdiction to conduct such a search under State law. These types of situations must be addressed in hospital policies that address both the legal authority for such interventions, as well as the specific criteria that must be met prior to carrying out such requests or directives from law enforcement.

## F. Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)

An ICF/IID must provide active treatment and all clients admitted to the ICF/IID must be in need of such services. The environment is developmental rather than medical and emphasis is placed upon training to enable each client to achieve their highest possible level of independence.

Because there are requirements particular to ICFs/IID, we are in the process of writing a separate communication on the topic of justice involved individuals in ICFs/IID. We invite advance questions and comments, which may be emailed to the mailbox listed below.

**Contact:** Please send all questions to SCGQAJusticeInvolved@cms.hhs.gov.

**Effective Date:** Immediately. This information should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators within 30 days of this memorandum. The contents of this letter supports activities or actions to improve patient or resident safety and increase quality and reliability of care for better outcomes.

/s/
*David R. Wright*

Attachment: Justice Involved Individuals Scenarios

cc: Survey and Certification Regional Office Management

[23] 42 CFR § 482.13(a)(2)
[24] 42 CFR § 482.13(b)(1)
[25] 42 CFR § 482.13(b)(2)
[26] 42 CFR § 482.13(d)

# Justice-Involved Individuals – SCENARIOS

*Revised 12.23.2016*
****Removed Scenario 3 – Inmate Edward Treated in the Hospital****

## Scenario 1 – Beatrice Who Has Dementia

Beatrice is a 72-year old currently incarcerated woman who was diagnosed with Alzheimer's disease at age 65. Since then, her physical and mental conditions have been steadily declining. She is able to participate in her activities of daily living but needs extensive cueing and assistance with toileting. She is pleasant, calm, oriented to self and some family members, but cannot recall the events that led to her arrest and imprisonment. Her family maintains contact with her and petitioned the court for compassionate release due to her advancing age as well as her physical and mental decline. Her children are unable to care for her at home and have been contacting local nursing homes for admission and long-term care. Because of Beatrice's condition the court has granted her a compassionate release without restrictions.

***Q: Can a nursing home with a dementia unit admit Beatrice without jeopardizing certification for Medicare or Medicaid?***

A: We do not see any significant risk in this case. The nursing home has an appropriate unit that can provide the needed services for Beatrice. Because her behavior does not appear to endanger the health, safety, or rights of other individuals, the facility is not likely to be challenged in its ability to concurrently provide a safe environment for other residents if they admit Beatrice. The situation would be the same if the correctional agency was seeking the placement because there was no family available.

## Scenario 2 –Secured Nursing Homes

XYZ Nursing Home was built to exclusively house individuals released from correctional facilities, either on compassionate release, as a condition of parole, or deemed incompetent to stand trial. The entire facility is locked and there is an onsite office maintained by the state parole board where parole officers are stationed. The nursing home has one physician who provides medical services to the residents and the residents are not free to choose their own attending physician.

All incoming mail and packages for residents are opened and searched by facility staff and any item deemed contraband is discarded. Resident rooms are searched on a daily basis for items that are not allowed, such as cell phones and picture frames containing glass or metal. Because cell phones are not allowed, there is only one telephone available for all residents and it is placed in the hallway next to the nurses' station with limited times for use and no privacy.

The nurses' station is completely enclosed in bullet-proof glass from floor to ceiling, with only a slot through which small items can be passed; similar to a bank teller's station.

***Q: Can XYZ Nursing Home be certified for Medicaid and would the State be able to obtain Federal Financial Participation?***

A: No. XYZ Nursing home could not be certified for Medicare or Medicaid. Without such certification, the State would not be eligible for Federal Financial Participation due to facility-wide policies and procedures that violate CMS' Requirements for Participation. For example, facility restrictions placed on the individual violate:

- The resident's right to privacy in written communication and to receive mail that is unopened,

- The right to have reasonable access to the use of a telephone where calls can be made without being overheard,
- The right to choose a personal attending physician,
- The right to be free from restraint or seclusion used for discipline,
- Additionally, the facility must provide a comfortable and homelike environment and allow the resident to use his or her personal belongings to the extent possible.

However, federal requirements do not prevent a State from operating or commissioning the operation of such a specialized facility. Since certification under Medicare or Medicaid would not be available, any public funding for such a facility would generally derive from State-only and/or local sources.

## Scenario *3* – Inmate John Treated in the Hospital & Transferred to a SNF

Inmate John, with a known diagnosis of epilepsy had a seizure that caused a life-threatening airway obstruction that required tracheal intubation and use of a mechanical ventilator. He was admitted to University Hospital for care. The care team's plan was that when John no longer needed the acute level of care provided at the hospital, he would be released to a nursing home with the capability of providing ventilator care. Once he gained strength, the facility staff would gradually reduce ventilator support so that John could be extubated and breathe on his own. The prison infirmary was not properly equipped and the staff was not trained for this specialized care.

***Q. Are there particular challenges for either the hospital or long term care facility in serving John and maintaining compliance with federal requirements?***

***Acute Care Hospital:*** We do not see significant risk in the hospital's ability to serve John and maintain compliance with the hospital CoPs. The acute care CoPs, designed for short-term treatment, do not have the same patient rights that are prominent in residential care environments (such as nursing homes) that are intended to function as an individual's home. An acute care hospital may be able to provide the care John needs and also not jeopardize its participation in Medicare and Medicaid if:

- The hospital ensured that all care provided to John is provided in a manner that maintained compliance with all hospital Conditions of Participation, including the Patient's Rights CoP expressed at 42 CFR 482.13.

The hospital did not act as the agent of law enforcement in enforcing any of the restrictions placed on John by the Department of Corrections. The use of soft restraints in an intubated patient may become necessary if the patient becomes agitated and attempts to remove his endotracheal tube because serious harm or death could occur otherwise. The patient's attending physician must be notified immediately to order the restraints. The hospital must have policies and procedures regarding the use of restraints to protect the patient from extubating himself.

***Nursing Home:*** A nursing home may be able to provide the care John needs and also not jeopardize its participation in Medicare and Medicaid if:

- The nursing home ensured that all care provided to John is provided in a manner that maintained compliance with all Requirements for Participation,
- The nursing home did not act as the agent of law enforcement in enforcing any restrictions placed on John by the Department of Corrections,
- The nursing home performed an adequate assessment of the resident's needs, preferences, and conditions which, in all likelihood, would involve reaching out to the responsible

caregivers of the environment(s) from which John is being transitioned to obtain pertinent information.

The determination may change as John's medical condition improves. For example, if John were successfully weaned from the ventilator in the nursing home, and if the Department of Corrections imposed additional restrictions on John, there would need to be a reassessment of whether or not the nursing home could provide care and continue to meet the Medicare/Medicaid requirements.

## Scenario *4* – Inmate Albert with Coronary Artery Disease

Inmate Albert developed mild chest pain and shortness of breath. He was transported to University Hospital and admitted to an area of the hospital that is leased by the Department of Corrections to provide inpatient medical care and services exclusively to prisoners. While under observation in the leased unit, Albert became increasingly short of breath and his chest pain worsened. The Department of Corrections clinical staff working in the leased unit determined that Albert needed an urgent medical evaluation to diagnose and treat his worsening symptoms. Albert was quickly transported to the ED of University Hospital. The medical screening examination determined Albert had blocked coronary arteries and required a coronary artery bypass graft, which was a service that could only be provided in the Medicare/Medicaid-certified area of University Hospital.

***Q: Can University Hospital provide services to Albert and still maintain compliance with Federal requirements?***

Department of Corrections or law enforcement agencies may enter into a contract with a Medicare/Medicaid-participating hospital to lease space in order to establish an inpatient prison healthcare facility. That leased space (which may or may not be locked) cannot participate in Medicare or Medicaid and must be distinct and separate from the certified hospital. The leased space is never considered a "unit" of the Medicare/Medicaid participating hospital. Although the prison inpatient healthcare facility could contract with the leasing hospital for some services, the hospital cannot share or co-mingle staff and services with the prison facility.

However, if a patient of the contracted prison healthcare facility requires care that is beyond the capabilities of the leased space, the patient may be evaluated in the ED and if needed, be admitted to the certified hospital (i.e., physically transferred from the "prison healthcare facility") to receive services that can be billed to Medicaid. Additionally, all Medicare requirements must be met by the hospital ED and inpatient units, including the hospital CoPs and EMTALA.

Therefore, Albert could initially be admitted to the area leased by the Department of Corrections, but would not be eligible for Medicaid benefits during his stay there. When he was admitted as an inpatient to the certified area of University Hospital for his coronary artery bypass graft and ICU stay, he would be Medicaid eligible and those services could be billed to Medicaid.

# SETTLEMENT AGREEMENT

## I. Recitals

1. Parties. The Parties to this Settlement Agreement (Agreement) are the Office of Inspector General (OIG) of the United States Department of Health and Human Services (HHS) and AnMed Health (Respondent)..

2. The Hospital is a Participating Provider. Respondent is a participating hospital that has entered into a provider agreement under section 1866 of the Social Security Act (Act) and has an emergency department (ED).

3. Description of Section 1867 of the Act. The Emergency Medical Treatment and Labor Act (EMTALA) requires that a participating hospital with an ED must provide, upon request, an appropriate medical screening examination, within the capability of the hospital's ED, to determine whether an emergency medical condition exists, as defined in section 1867(e)(1) of the Act. 42 U.S.C. § 1395dd. If an individual has an emergency medical condition, the hospital must provide, within the capabilities of the staff and facilities available at the hospital, treatment to stabilize the condition, unless a physician certifies that the individual should be transferred because the benefits of medical treatment elsewhere outweigh the risks associated with transfer. If a transfer is ordered, section 1867(c) of the Act requires that the transferring hospital provide stabilizing treatment to minimize the risks of transfer. A receiving hospital that has specialized capabilities may not refuse to accept an appropriate transfer of a patient who requires such capabilities. 42 U.S.C. § 1395dd(g).

4. Description of Civil Monetary Penalty. Section 1867(d)(1)(A) of the Act provides that "[a] participating hospital that negligently violates a requirement of this section is subject to a civil money penalty of not more than $50,000 (or not more than $25,000 in the case of a hospital with less than 100 beds) for each such violation."

5. Covered Conduct. The OIG conducted an investigation regarding allegations that Respondent violated section 1867 of the Act. Based on its investigation, the OIG identified 36 incidents in which AnMed appeared to have violated section 1867 of the Act. In these incidents, individuals presented to AnMed's ED with unstable psychiatric emergency medical conditions. Instead of being examined and treated by on-call psychiatrists, patients were involuntarily committed, treated by ED physicians and kept in AnMed's ED for days or weeks instead of being admitted to AnMed's psychiatric unit for stabilizing treatment. The following are examples of such incidents:

- A.M., a 32-year old female, presented to AnMed's ED via law enforcement on 7/6/2012 with psychosis and homicidal ideation and was involuntarily committed. A.M. did not receive psychiatric examination or treatment by available Anmed psychiatrists and was not admitted to the psychiatric unit

for stabilizing treatment. Instead, A.M. was kept in the ED for 38 days and at one point was seen by a psychiatrist from another facility that was familiar with her condition. He then prescribed a variety of medications for agitation. A.M. eventually reached her baseline and her involuntary commitment was decertified and she was discharged home.

- C.I., a 55-year old female, presented to AnMed's ED on 5/25/2012 catatonic with a history of schizophrenia and prior catatonic episodes. An AnMed ED physician completed a medical screening examination that included blood work, thyroid stimulating hormone, and a CAT scan of the brain. C.I. was involuntarily committed and spent 7 days in the ED. C.I.'s medical record did not indicate that she was evaluated or treated by an AnMed on-call psychiatrist.

- M.N., a 62-year old female, was brought to AnMed's ED by a detention officer on 8/1/2012. M.N. had pulled a knife on family members and was suffering from acute psychosocial issues. She received a medical screening examination by an ED physician, but did not receive examination or treatment by available on-call psychiatrists at AnMed. She was involuntarily committed and stayed in AnMed's ED for 20 days before she was transferred to another health care facility.

In each of the incidents described above, Anmed had on-call psychiatrists and beds available in its psychiatric unit to further evaluate and/or stabilize the patient's emergency medical condition.

Similar incidents occurred for the following individuals presenting to AnMed's ED: KM (1/3/2013, in ED 12 days); CB (9/23/2012, in ED 9 days); CS (11/20/2012, in ED 9days); MW (1/31/2013, in ED 13 days); JH (1/11/2013, in ED 15 days); DH (10/15/2012, in ED 7 days); JM (9/25/2012, in ED 10 days and on 11/12/2012, in ED 10 days); RH (11/14/2012, in ED 13 days); DC (1/15/2013, in ED 8 days); DS (9/13/2012, in ED 6 days); UB (9/16/2012, in ED 15 days); CS (10/29/2012, in ED 15 days); JB (11/20/2012, in ED 14 days); TM (12/15/201, in ED 24 days); DB (10/22/2012, in ED 6 days); JH (11/23/2012, in ED 11 days); JF (2/28/2013, in ED 11 days); KT (6/28/2013, in ED 13 days); CP (5/3/2013, in ED 8 days); NL (5/15/2013, in ED 7 days); BE (3/4/2013, in ED 8 days); CP (6/11/2013, in ED 10 days); SP (2/27/2013, in ED 6 days); LH (5/16/2013, in ED 13 days); TS (10/11/2012, in ED 11 days); LM (8/16/2012, in ED 11 days); MC (7/17/2013, in ED 7 days); AL (8/27/2012, in ED 9 days); JD (4/13/2012, in ED 10 days); JJ (8/22/2012, in ED 7 days); OD (4/01/2012, in ED 11 days); and TK (7/21/2013, in ED 11 days). In each of these cases the individual had a psychiatric emergency medical condition and OIG concluded AnMed had the capabilities to provide appropriate

psychiatric evaluation and treatment to stabilize these emergency medical conditions. In each case the individual was not examined and/or treated by an AnMed psychiatrist.

AnMed kept these 35 individuals in its ED, pursuant to a longstanding policy of not admitting involuntary patients to its psychiatric unit. AnMed's policies provided that if an individual should be involuntarily committed and did not have financial resources, the attending physician could write an order for the local mental health center to evaluate the patient for commitment to the state mental health system after the patient is medically stable. These individuals were kept in AnMed's ED for 6 –38 days each until they were discharged or transferred to another medical facility. These individuals ranged in age from young adults to elderly adults. Most of them were suicidal and/or homicidal and suffered from depression, schizophrenia, bipolar disorder, drug abuse, psychosis, personality disorders and other serious psychiatric disorders.

The 36 presentments referred to above constitute the "Covered Conduct". This Agreement resolves the OIG's investigation pertaining to these alleged violations.

6. No Admission or Concession. This Agreement is neither an admission of liability by Respondent nor a concession by the OIG that its claims are not well founded.

7. Intent of Parties to Effect Settlement. In order to avoid the uncertainty and expense of litigation, the Parties agree to resolve this matter according to the terms and conditions delineated below.

## II. Terms and Conditions

8. Payment. Respondent agrees to pay to the OIG $1,295,000 (Settlement Amount). This payment shall be made via wire transfer to the United States Department of Health and Human Services according to written instructions provided by OIG. Respondent shall make full payment no later than three business days after the Effective Date.

9. Release by OIG. In consideration of the obligations of Respondent under this Agreement and conditioned upon Respondent's full payment of the Settlement Amount, the OIG releases Respondent from any and all claims or causes of action against Respondent for civil monetary penalties or other action under section 1867(d)(1) of the Act, 42 U.S.C. § 1395dd(d)(1), for the Covered Conduct. The OIG and HHS do not agree to waive any rights, obligations, or causes of action other than those specifically referred to in this Paragraph. This release is applicable only to Respondent and is not applicable in any manner to any other individual, person, partnership, operation, or entity.

10. Release by Respondent. Respondent shall not contest the Settlement Amount under this Agreement and any other remedy agreed to under this Agreement. Respondent waives all procedural rights granted under the Civil Monetary Penalties Law or EMTALA (42 U.S.C. §§ 1320a-7a and 1395dd), related regulations (42 C.F.R. Part 1003), and the HHS claim collections regulations (45 C.F.R. Part 30), including but not limited to notice, hearing, and appeal with respect to the Settlement Amount.

11. Reservation of Claims. Notwithstanding any term of this Agreement, specifically reserved and excluded from the scope and terms of this Agreement as to any entity or person (including Respondent) are the following:

a. Any criminal, civil, or administrative claims arising under Title 26 U.S. Code (Internal Revenue Code);

b. Any criminal liability;

c. Except as explicitly stated in this Agreement, any administrative liability, including mandatory and permissive exclusion from Federal health care programs; and

d. Any liability to the United States (or its agencies) for any conduct other than the Covered Conduct.

12. Binding on Successors. This Agreement shall be binding on Respondent and the heirs, successors, assigns, and transferees of Respondent.

13. Costs. Each Party to this Agreement shall bear its own legal and other costs incurred in connection with this matter, including the preparation and performance of this Agreement.

14. No Additional Releases. This Agreement is intended to be for the benefit of the Parties only, and by this instrument the Parties do not release any claims against any other person or entity.

15. Effect of Agreement. This Agreement constitutes the complete agreement between the Parties. All material representations, understandings, and promises of the Parties are contained in the Agreement. Any modifications to this Agreement shall be set forth in writing and signed by all Parties. Respondent represents that this Agreement is entered into with the advice of counsel and knowledge of the events described herein. Respondent further represents that this Agreement is voluntarily entered into in order to avoid litigation, without any degree of duress or compulsion.

16. Effective Date. The Effective Date of this Agreement shall be the date of signing by the last signatory.

17. Disclosure. Respondent consents to OIG's disclosure of this Agreement, and information about this Agreement, to the public.

18. Execution in Counterparts. This Agreement may be executed in counterparts, each of which constitutes an original, and all of which shall constitute one and the same agreement.

19. Authorizations. The individuals signing this Agreement on behalf of the Respondent represent and warrant that they are authorized by Respondent to execute this Agreement. The individuals signing this Agreement on behalf of the OIG represent and warrant that they are signing this Agreement in their official capacities and that they are authorized to execute this Agreement.

**RESPONDENT**

6/2/17
Date

Timothy B. Arellano
General Counsel
AnMed Health

6/2/17
Date

Alice V. Harris
Counsel for AnMed Health

**OFFICE OF INSPECTOR GENERAL**

6/23/17
Date

Robert K. DeConti
Assistant Inspector General for Legal Affairs
Office of Counsel to the Inspector General
Office of Inspector General
U.S. Department of Health and Human Services

6/16/2017
Date

Sandra Jean Sands
Senior Counsel
Office of Counsel to the Inspector General
Office of Inspector General
U.S. Department of Health and Human Services