July 10, 2024

U.S. Department of Health and Human Services
Office of Inspector General
Attn: OIG Hotline Operations
P.O. Box 23489
Washington, DC 20026

Office for Civil Rights
U.S. Department of Health and Human Services
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Director of Division of Long-Term Services and Supports
Centers for Medicare and Medicaid Services
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Re: Complaint Against Utah Department of Health and Human Services and Request for OIG, OCR, and CMS Assistance and Intervention

Dear Administrators & Investigators,

The Disability Law Center (DLC) is the designated protection and advocacy agency (P&A) for the state of Utah. The DLC's work as a P&A includes monitoring facilities where individuals with disabilities reside for abuse, neglect, or other substandard conditions. The National Health Law Program (NHeLP) has been a national leader in *Olmstead* and long-term care quality advocacy and has been engaged with the DLC throughout its long-term care advocacy, providing technical assistance and other advocacy support.

For nearly a decade, the DLC has repeatedly asked Utah's Department of Health and Human Services[1] (DHHS) to address the systemic failure of its oversight agencies to

[1] The Utah Department of Health and the Utah Department of Human Services combined to form one agency in the summer of 2023. State Survey, Medicaid and Licensing are currently

fulfill their fundamental duty to protect the health and safety of people receiving long-term services and supports (LTSS). We are concerned that federal dollars are being spent to monitor and pay facilities that are known by the State not to meet minimum health and safety standards, including facilities receiving enhanced Medicaid reimbursement rates under the Upper Payment Limit demonstration (UPL). DHHS has failed to meet its minimum obligations to ensure that the conditions of participation are met through its survey agency, that the health and welfare in community settings is maintained, and that individual rights are protected. Investigations by DHHS fail to identify clear instances of abuse and do not take appropriate action to ensure facilities remediate or cease operations (and do not reappear under a different name). NHeLP and the DLC request assistance to address these significant systemic failures of Utah DHHS.

While the Centers for Medicare &Medicaid Systems (CMS) has intervened in Utah previously by using its look behind authority, we believe that the ongoing, profound failure of DHHS's oversight requires additional measures to be taken by CMS, the Office of Inspector General (OIG) and the Office for Civil Rights (OCR). We make several requests for investigation and action:

- CMS use its look behind authority to cancel and invalidate contracts with Medicaid facilities that do not meet the regulatory minimum health and safety standards, that Utah DHHS receive a revised certification allocation, that Utah be placed under a compliance plan for waiver operations, and that Utah receive supervision and technical assistance from CMS to improve its oversight processes.
- OIG audit Utah DHHS to ensure that federal monies are spent on (1) administrative activities that adequately perform their contracted and expected functions, and (2) services that meet minimum standards for health and safety.
- OIG review the UPL demonstration to ensure that the structure and reimbursements comply with federal regulation, and that if not, OIG require repayment of funds as has occurred in other states utilizing the UPL.
- The relevant entities investigate DHHS' failure to communicate with individuals with disabilities and to provide equitable access to effective oversight and investigations by HHS-funded state agencies. While some of the facilities discussed have been closed, new facilities have opened and intervention is needed to stop ongoing and future harm; and
    - Any other actions necessary to remediate the problems identified.

within DHHS but have previously been housed within two different departments. For purposes of this report, we will refer to agency actions as DHHS unless it is necessary for clarity to refer to a specific agency within the department.

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## I. Executive Summary

Residents in long-term care services, whether institutional or community-based are supposed to be protected from abuse and neglect through regulations, conditions of participation, and other licensure requirements. Critically, states must oversee compliance with these requirements, including through investigation of incidents and taking all appropriate action to enforce compliance and protect individuals with disabilities in these settings. This generally occurs through certification and licensure compliance, especially the activities of the state survey agency. The problems in these settings are not new and multiple reports have identified the need for adequate investigatory and compliance activities

### A. Renewed Federal Efforts to Protect Residents in Long-term Care Services

The COVID-19 pandemic put a spotlight on the existing problems in long-term care services. Decades of inadequate staffing levels, poor infection control, crowded facilities, and a lack of oversight were suddenly lethal to residents and staff living and working in long-term care facilities. In 2022, the Biden administration announced a set of historic reforms to the long-term care sector to ensure patient safety and safeguard public dollars from being spent on facilities that refuse to comply with Medicaid requirements.[2] Key goals announced by the administration included terminating funding for facilities that do not improve, escalating enforcement for facilities that fail to comply with federal requirements, and requiring systemic improvements that are targeted at fixing quality concerns.[3] Additionally, both Congress and the Biden administration have voiced serious concerns about the influence of private equity and other ownership models that seek to maximize profits by inadequately staffing facilities which inherently leads to a high risk of abuse and neglect of residents in long-term care.[4] This aggressive agenda makes clear

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[2] *See* White House, Fact Sheet: Protecting Seniors by Improving Safety and Quality of Care in the Nation's Nursing Homes (Feb. 28, 2009), https://www.whitehouse.gov/briefing-room/statements-releases/2022/02/28/fact-sheet-protecting-seniors-and-people-with-disabilities-by-improving-safety-and-quality-of-care-in-the-nations-nursing-homes/; *see also* Consumer Voice, Biden Announcement Summary (2022), https://theconsumervoice.org/uploads/files/actions-and-news-updates/Biden_Announcement_Summary.pdf.

[3] Press Release, HHS, Biden-Harris Administration Strengthens Oversight of Nation's Poorest Performing Nursing Homes (Oct. 21, 2022), https://www.hhs.gov/about/news/2022/10/21/biden-harris-administration-strengthens-oversight-of-nations-poorest-performing-nursing-homes.html.

[4] Press Release, HHS, Biden-Harris Administration Makes More Medicare Nursing Home Ownership Data Publicly Available, Improving Identification of Multiple Facilities Under Common Ownership (Sept. 26, 2022), https://www.hhs.gov/about/news/2022/09/26/biden-harris-administration-makes-more-medicare-nursing-home-ownership-data-publicly-available-improving-identification-of-multiple-facilities-under-common-ownership.html; Press Release, Centers for Medicare & Medicaid Servs., Biden-Harris Administration Takes Historic Action to Increase Access, Quality Care, and Support for Families (Oct. 18,

that long-term care facilities with a record of repeated and serious violations should no longer be allowed to keep the status quo using public monies.

Similar initiatives to address health and safety in community group home settings have been championed by HHS OIG, OCR and the Administration for Community Living (ACL). In 2018, these agencies issued a report finding that individuals residing in group homes, including those funded through Medicaid, were at serious risk of harm due to a lack of oversight by state Medicaid agencies.[5] The report found that state Medicaid agencies failed to report and monitor critical incidents[6] and in response to these deficiencies developed model practices for states to fulfill their health and safety oversight obligations.[7]

**B. The Role of State Survey Agencies**

State survey agencies are pivotal to ensuring patient safety and are required by agreements with the Federal government to "survey[] for the purpose of certifying to the Secretary the compliance or non-compliance of providers[.]"[8] States are also required to "apply the appropriate Conditions of Participation, Conditions for Coverage, and Requirements for Participation in accordance with CMS regulations and instructions."[9] States receive federal dollars to perform a critical oversight function on behalf of CMS in a manner that follows federal requirements—not the philosophy or preferences of an individual state. A state's survey process must be able to ensure that regulatory minimum health and safety standards are met.[10] Similarly, DHHS has an obligation to maintain the health and welfare of HCBS waiver participants, including in licensed settings. Yet, DHHS leadership has stated numerous times that its licensing philosophy is guided by maintaining facilities, even when obvious health and safety concerns persist. An overview

2022), https://www.cms.gov/newsroom/press-releases/biden-harris-administration-takes-historic-action-increase-access-quality-care-and-support-families.

[5] Joint Report of U.S. Dept. of Health & Human Servs, Office of Inspector General, Admin. for Cmty. Living, & Office of Civil Rights, *Ensuring Beneficiary Health and Safety in Group Homes Through State implementation of Comprehensive Compliance and Oversight* (Jan. 2018), https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/report_joint_report_hcbs.pdf.

[6] *Id.*

[7] *Id.* at 7. *See also* Ensuring Access to Medicaid Servs., 89 Fed. Reg. 40542 (May 10, 2024) (setting forth new requirements for monitoring access to services and incident management).

[8] Ctrs. for Medicare & Medicaid Servs., Ctr. for Clinical Stds. & Quality, Dear State Survey Agency Directors Letter, QSO-22-12-ALL, State Obligation to Survey to the Entirety of Medicare and Medicaid Health and Safety Requirements under the 1864 Agreement 2 (Feb. 9, 2022), https://www.cms.gov/files/document/qso-22-12-all.pdf [hereinafter CMS State Survey Letter].

[9] *Id.*

[10] *Id.*

of how DHHS continues to be driven by this philosophy is included in this section and DHHS's systemic oversight deficiencies will be discussed in greater detail *infra*.

### C. Utah DHHS Wrongly Redefines its Oversight Role to the Detriment of Safety, Fails to Act Absent Public Pressure, and Does Not Take Sufficient Corrective Action

Utah DHHS has not followed the administration's call to hold providers accountable. DHHS has failed to meet its federal mandate to ensure basic health and safety standards are met and that there is a prudent use of federal dollars across its disability service system. The agency has repeatedly stated it will not act against dangerous providers due to the lack of an adequate provider network.

For example in 2022, investigative reporting into Utah's youth residential treatment facilities (YRTF), including the federally regulated psychiatric residential facilities (PRTF), documented ongoing and widespread abuse and a reluctance by DHHS to hold facilities accountable.[11] Reporting showed past DHHS licensing directors had described their role as providing "technical assistance" with the aim of helping businesses to stay open.[12] After the state passed more stringent oversight laws, a DHHS licensing official was quoted as saying "I have realized that we need to hold these programs accountable."[13]

A year later, in 2023, the DLC released its report describing the death of Chien Nguyen, who lived at two separate facilities with inhumane conditions including raw sewage, bed bug infestations, inadequate staffing, and a failure to provide critical psychiatric care resulting in his death. The report was critical of DHHS's failure to close the facilities in question. DHHS responded to the report by publicly stating "[t]he state must maintain a balance: Ensure there are safe places for individuals to be cared for and that enough private programs remain available for people to live."[14] DHHS further stated that they cannot risk closing a program too quickly without having placements for individuals to transfer to;[15] this response ignores the fact that the dangerous conditions at these two facilities persisted for years.

We recognize the state is obligated to ensure there are a sufficient number of Medicaid facilities, but this is not the state survey agency's obligation. The state survey

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[11] Jessica Miller & Will Craft, *More Citations and New Concerns Follow Utah's Increased Oversight of Troubled-Teen Industry,* APM REPORTS (Apr. 12, 2022), https://www.apmreports.org/story/2022/04/12/utah-increased-oversight-of-troubled-teen-industry.
[12] *Id.*
[13] *Id.*
[14] Tracy Gruber, *The Disability Law Center Report is Important, but Not the Whole Story*, THE SALT LAKE TRIB. (July 8, 2023), https://www.sltrib.com/opinion/commentary/2023/07/08/tracy-gruber-disability-law-center/.
[15] *Id.*

agency's obligation is to ensure Medicaid funded facilities are compliant with the conditions of participation under federal law. Moreover, the State does not have a "balance" as it consistently keeps known, dangerous facilities open. For example, DHHS declined to close the federally regulated psychiatric hospital, Highland Ridge; also referred to as "The Rape Hospital" by its employees and outside investigators because of how often patients were sexually assaulted and how infrequently the staff reported these incidents to police.[16] Allegations included staff being instructed not to call 9-1-1 when a patient was physically or sexually assaulted and one instance of a patient whose death was not reported until rigor mortis set in.[17] The hospital CEO was quoted as saying that "he doesn't have enough staff to keep everyone safe."[18] In September of 2023, DHHS stated that it would not move to close the facility because Utah has only a few psychiatric hospitals and shutting a facility is challenging, despite the overwhelming evidence and admissions by the hospital CEO that patients were being actively harmed.[19] It was not until the local press covered DHHS' failure to address the ongoing safety concerns at Highland Ridge in October of 2023 that the agency took steps that led to the appointment of a full-time monitor.

In March of this year, local news reported on Benchmark Behavioral Health, a boys-only PRTF. The facility had 61 reports of assault and 36 reports of sexual assault since 2019.[20] Local news declined to publish the details of several cases citing that they are too graphic for publication.[21] Inspections records showed reports of a child being assaulted approximately 40 times, a suicide attempt by a child that the facility failed to report, and a failure to notify parents after reports of physical and sexual assaults.[22] In 2022, DHHS placed Benchmark on a conditional license, but declined to reinstate a conditional license in 2023, even though DHHS records showing that children were stealing medication, children were huffing aerosols and drinking hand sanitizer, and that a failure of supervision led to a child swallowing 2 batteries.[23]

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[16] Adam Herberts, *Utah Department of Health Justifies Not Shutting Down 'Rape Hospital',* FOX 13: FOX 13 Investigates (Sept. 10, 2023), https://www.fox13now.com/news/fox-13-investigates/utah-department-of-health-justifies-not-shutting-down-the-rape-hospital.
[17] Adam Herberts, *Lawmakers Call for Shutdown of Utah Psychiatric Hospital,* FOX 13: FOX 13 Investigates (Oct. 18, 2023), https://www.fox13now.com/news/fox-13-investigates/lawmakers-call-for-shutdown-of-utah-psychiatric-hospital.
[18] *Id.*
[19] *Id.*
[20] Adam Herberts, *This Psychiatric Hospital Has More Child Assault Cases Than Any Other in Utah,* FOX 13: FOX 13 Investigates (Mar. 18, 2024), https://www.fox13now.com/news/fox-13-investigates/this-psychiatric-hospital-has-more-child-assault-cases-than-any-other-in-state-of-utah.
[21] *Id.*
[22] *Id.*
[23] *Id.*

In 2024, after the news uncovered the high number of alleged assaults at Benchmark, the director of the Office of Licensing for DHHS, commented "The goal is not to shut people down. The goal is to help them become better providers."[24] The director then thanked the reporter stating, "I appreciate you looking at those police records because there are times-things that we don't see, [s]o we've also requested those police records." The director's seemingly lackadaisical response was concerning because under federal guidelines, PRTFs must report a serious occurrence to the state Medicaid agency the next business day.[25] Shortly after the news story was published, Benchmark Behavioral was put on a conditional license.[26] Benchmark Behavioral Health's parent company, Universal Health Services also owns Provo Canyon School and Copper Hills Youth Centers, two PRTFs that have also been plagued with complaints of physical abuse and sexual assault as well as a failure of oversight.[27] We believe that throughout this time, these facilities continued to admit and bill Medicaid for services provided.[28]

Based on the conditions DHHS allows, it is unclear what kind of facility misconduct would merit Utah's state survey agency taking more stringent measures up to and including licensing revocation. The psychiatric hospital known as "The Rape Hospital" closed because the facility chose to relinquish its license rather than come into compliance with state and federal regulations, only after years and years of operating under allegations of abuse and police reports. Even a private insurer cut ties with Highland

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[24] *Id.*

[25] *Id.*; 42 C.F.R. § 483.374(b)(3).

[26] Letter from Carmen Richins, DHHS Dir. of Licensing and Background Checks, to Craig Scholnik, Adm'r of Benchmark Behav. Health Sys., (Mar. 29, 2024) https://bbhsnet.com/wp-content/uploads/2024/04/Benchmark-Conditional-Letter-March-2024.pdf.

[27] Julie Lurie, *Inside the Psychiatric Hospitals Where Foster Kids Are a "Gold Mine,"* Mother Jones, Sept.- Oct. 2023, https://www.motherjones.com/criminal-justice/2023/10/foster-kids-psychiatric-hospitals-universal-health-services-uhs-alaska-cps/; Annie Knox, *Lawsuit: Utah Youth Center Failed to Supervise Kids Who Victimized Boy,* Deseret News (Aug. 27, 2019), https://www.deseret.com/utah/2019/8/27/20835660/lawsuit-utah-youth-center-failed-to-supervise-kids-who-victimized-boy/.

[28] The DLC has seen similar concerns in state regulated long-term care facilities. Diamond Ranch, a Youth Residential Treatment Facility (YRTF) with longstanding health and safety concerns was allowed to continue operating for nearly eight months after a child died there. A new YRTF is being permitted to open on the same location with the same staff as Diamond Ranch. Jessica Miller, *After a Girl's Death, Utah Closed Diamond Ranch Acad. A New Program May Open in the Same Spot with Some of the Same Emps.*, SALT LAKE TRIB. (Mar. 12, 2024, 6:00 AM), https://www.sltrib.com/news/2024/03/12/after-girls-death-utah-closed/; *see also* U.S. Senate Special Comm. on Aging, *Uninspected and Neglected: Nursing Home Inspection Agencies are Severely Understaffed, Putting Residents at Risk* 1 (2023), https://www.aging.senate.gov/imo/media/doc/UNINSPECTED%20&%20NEGLECTED%20-%20FINAL%20REPORT.pdf (national report on PRTFs, including those of Universal Health Services) [hereinafter PRTF Senate Report].

Ridge in September of 2023 after the media reported on its misconduct. Had the facility not closed voluntarily, it would likely still be in operation and serving patients. In March 2021, prior to Chien Nguyen's death, the facility where he was housed received only a $1000 civil monetary penalty (CMP) after a resident had their arm broken and their eyes gouged out. This individual was left alone with another resident who required a 24-hour line-of-sight staff supervision. Only a month after this serious incident the facility's conditional license was removed yet serious and persistent understaffing issues remained. Like the previous resident, Chien would be left alone due to understaffing, ultimately resulting in his death.[29]

We are gravely concerned that DHHS fails to meet its obligations as the state survey agency. During a recent legislative committee hearing, an assistant deputy director of DHHS was questioned about why "The Rape Hospital" was allowed to operate for so many years without effectively addressing the serious reports of physical abuse. The deputy director testified that CMS regulations prevented the state survey agency from doing so because the CMS survey and certification process amounted to "a slap on the hand" that did not require a facility to fix the root cause of the harm.[30] Once the facility met the plan of correction, they were given a "clean slate" and allowed to start over without consideration of past conduct.[31] DHHS made other assertions that were contrary to federal guidance and represented to the legislature that they were not allowed to make unannounced visits to the hospital under the CMS guidelines.[32] The deputy director testified that it was not until the office went through a process to align the CMS certification process with state statutes and regulation, that the state survey agency was able to bring more effective enforcement actions such as installing an independent monitor,[33] which is patently untrue.

Although some facilities discussed herein have closed, these closures only came after intense pressure was placed on the state through DLC activity and public scrutiny—not as a result of an effective state oversight system. Absent such pressure, the vast

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[29] This, and other similar instances of repeated occurrences of the same type of harms at long-term care facilities, raises concerns that DHHS is approving plans of correction that are either ineffective or not implemented.

[30] Video Recording, Utah Legislature, Health & Hum. Servs. Interim Comm. (May 15, 2024), https://le.utah.gov/av/committeeArchive.jsp?mtgID=19414.

[31] *See Id.; see also* Adam Herbets, *Health Dep't. Says FOX 13 News Helped Them Realize Discipline of Psych Hospitals. 'Didn't Make Sense,'* FOX 13 (May 25, 2024, 9:57 PM), https://www.fox13now.com/news/fox-13-investigates/health-department-says-fox-13-news-helped-them-realize-discipline-of-psych-hospitals-didnt-make-sense.

[32] Utah Legislature, *supra* note 30; *see also* Center for Medicare & Medicaid Servs., State Operations Manual, App. A – Survey Protocol, Regulations, and Interpretive Guidelines for Hospitals 3 (2024), https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/som107ap_a_hospitals.pdf ("All hospital surveys are unannounced. Do not provide hospitals with advance notice of the survey.").

[33] Utah Legislature, *supra* note 30.

majority of failing facilities will continue to operate without interruption despite the physical, mental, and emotional harm caused to individuals with disabilities. The State has a long, repeated history of insufficient monitoring, failure to take action, failure to adhere to federal requirements to ensure health and welfare, inability to recognize abuse and neglect, failure to communicate with individuals during monitoring and investigations, insufficient action in the face of abuse and neglect, and lack of investigation to prevent facilities from merely opening under a new name but with no actual changes.

### D. Request for Federal Intervention

Without intervention from OIG, OCR, and CMS, we fear that public monies will continue to be spent on ineffective oversight and facilities that are unable to meet the minimum health and safety standards. Utah's state survey agency has shown its processes for ensuring compliance with federal standards is substantially deficient and that surveyors fail to implement federal licensing regulations.[34] For example, the facility where Chien died was allowed to operate for a year after his death, until two staff members were arrested for their role in his death. DHHS officials stated they could only revoke the facility's license because two staff members were arrested but no new facts were uncovered due to the arrests. Federal guidance makes clear that decisions about termination include considerations such as the existence of immediate jeopardy and actual harm to residents, and if a facility has a history of non-compliance—not whether employees have been arrested for conduct that occurred in the year prior. If it was appropriate to close the facility after the arrests, it was appropriate to close the facility at the time of Chien's death.

When considering the long-term care facilities, DHHS has cited a lack of resources and services for patients as a reason to continue operating a dangerous facility. However, states can use CMP funds for assistance and support to protect the residents of a facility that is closing.[35] If the state is concerned about a lack of service providers, this is something the state Medicaid agency is obligated to remedy while the state survey agency should be assessing the immediate harm to patients and how to protect their physical wellbeing.[36] These deficiencies demonstrate the need for federal assistance to ensure that DHHS understands its obligations, the available regulatory tools, and is able to effectively oversee Medicaid funded facilities.

[34] These oversight processes are implemented in such a way that denies access and effective communication to people with disabilities in violation of Title II of the ADA, Section 504 of the Rehabilitation Act, and Section 1557 of the ACA. *See* IV.E *infra.*
[35] Ctrs. for Medicare & Medicaid Servs., Ctr. for Clinical Stds. & Quality, State Survey Agency Directors Letter, QSO-23-23-NHS, Civil Money Penalty Reinvestment Program (MPRP) Revisions (Sept. 25, 2023), https://www.cms.gov/files/document/qso-23-23-nhs.pdf.
[36] 42 U.S.C. § 1396a(a)(5), (8)

## II. Legal Authority

### A. CMS Authority

Under Section 1864 of the Social Security Act, CMS contracts with State Survey Agencies to certify compliance with Federal requirements for Medicare and Medicaid providers. Under the Act, CMS has authority to question State determinations regarding Medicaid facilities' compliance with Federal requirements and authorizes CMS to cancel approval of all Medicaid facilities that do not meet Federal health or safety requirements.[37] CMS may also invalidate provider agreements and the entitlement of the State to federal financial participation when the State fails to adhere to federal procedures.[38] On February 9, 2022, CMS issued a memo reminding states of their licensing agency obligations to ensure "regulatory minimum health and safety standards have been met."[39] The memo warns "States that fail to perform survey and certification functions in a manner sufficient to assure the CMS of the full certification of compliance with all Conditions of Participation, Conditions for Coverage, and Requirements for Participation for providers and suppliers, may, among other things, receive a revised Survey and Certification budgetary allocation."[40] CMS also has the authority to enforce compliance with the requirements of home and community-based waiver programs, including ensuring the health and welfare of participants.[41]

Moreover, Medicaid payments, including supplemental payments like UPL demonstration projects as described below, are required to be consistent with the principles of efficiency, economy and quality of care.[42] CMS has the authority to oversee UPL programs. In 2019, CMS proposed increased regulation of UPL programs (later withdrawn) stating "We have seen a proliferation of payment arrangements that mask or circumvent the rules where shady recycling schemes drive up taxpayer costs and pervert

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[37] 42 U.S.C. § 1396a(a)(33); 42 U.S.C. § 1396r(g)(3); 42 U.S.C. § 1396i(b)(1); *see also* 42 C.F.R. §§ 442.30; 431.610(g); Ctrs. for Medicare & Medicaid Servs. State Operations Manual, ch. 3 § 3042 (2020), https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/som107c03pdf.pdf; Ctrs.for Medicare & Medicaid Servs., State Medicaid Manual § 2084.3.

[38] CMS has two types of look behind authority (1) to cancel approval of a facility to participate in Medicaid if it fails to comply substantially with the Conditions of Participation or regulatory standards; and (2) to consider the provider agreement invalid from the date of inception for purpose of providing federal financial participation (FFP) to the State if the State failed to adhere to federal procedures. 42 C.F.R. § 442.30; *see also* State Medicaid Manual § 2084.3(C); State Operations Manual § 3042.

[39] State Survey Letter, *supra* note 7.

[40] *Id.*

[41] 42 U.S.C. § 1396n.

[42] 42 U.S.C. § 1396a(a)(30)(A).

the system."[43] CMS has indicated that it is particularly concerned about "private-public partnerships in which a private entity agrees to provide a service or other in-kind value to further the purpose of the government entity"[44] and required repayment from states with private-public partnership UPL models very similar to that found in Utah.[45]

### B. Health and Human Services Office of Inspector General Authority

OIG has the authority to investigate fraud, waste or abuse relating to HHS grants or contracts and abuse or neglect in nursing homes and other long-term care facilities."[46] OIG's mission "is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components."[47] OIG's authority extends to State Medicaid agencies, payment of federal financial participation, and the use of UPL demonstrations.[48]

### C. Health and Human Services Office for Civil Rights Authority

HHS OCR enforces Section 504 and 508 of the Rehabilitation Act, Title II of the Americans with Disabilities Act and Section 1557 of the Affordable Care Act.[49] Under

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[43] Disability L. Ctr., THE DANGERS OF INST. LIVING: COVID-19 IN UTAH'S LONG-TERM CARE FACILITIES 16 (2023) https://disabilitylawcenter.org/wp-content/uploads/2023/05/The-Dangers-of-Institutional-Living-COVID-19-in-Utahs-Long-term-Care-Facilities.pdf.

[44] Jordan Kearny, *Increased Enforcement of Limitation on Upper Payment Limit Payments,* AHLA CONNECTIONS 15 (2016), https://sharepoint.healthlawyers.org/News/Connections/Documents/2016/Feature/ac1605_Feature.pdf.

[45] Letter from Emily Blandford, NCSL Health Program, to Russell Frandsen (Oct. 3, 2022), https://le.utah.gov/interim/2022/pdf/00003831.pdf.

[46] Inspector General Act of 1978, as amended, 5 U.S.C. app. 3; Health Insurance Portability and Accountability Act of 1996 (HIPAA), establishing the Health Care Fraud and Abuse Control Program, 42 U.S.C. §§ 1320a-7c, 1395i-5(k); American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5; Patient Protection & Affordable Care Act, Pub. L. No.111-148, *amended by* the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152.

[47] U.S. Dep't of Health & Human Servs. Office of Inspector Gen., *Review of Medicaid Upper-Payment-Limit Requirements for Kansas Nursing Facility Reimbursement* 6 (Feb. 9, 2005), available at https://oig.hhs.gov/oas/reports/region7/70302672.pdf.

[48] *Supra* note 46.

[49]. *See, e.g.,* U.S. Dep't of Health & Human Servs., Office for Civil Rights, Dear State Health official letter re Ensuring Language Access for Limited English Proficient (LEP) Individuals and Effective Communication for Individuals with Disabilities During the States' Unwinding of the Medicaid Continuous Enrollment Condition (Apr. 4, 2023), https://www.hhs.gov/sites/default/files/medicaid-unwinding-letter.pdf. The Americans with Disabilities Act prohibits discrimination on the basis of disability by public entities. 42 U.S.C. §§ 12131-12134. The ADA regulations generally designate HHS as the agency with responsibility for investigating complaints of discrimination in "programs, services, and regulatory activities

these provisions covered entities are prohibited from discrimination on the basis of disability, entities must provide people with disabilities equal opportunity to participate in and benefit from programs, and must communicate effectively with individuals with disabilities.[50] Covered entities must not use criteria or methods of administration that discriminate on the basis of disability.[51] States must meet affirmative obligations to avoid discrimination and ensure program recipients have access to the benefits to which they are legally entitled.[52]

## III. A Historical Failure to Provide Oversight—The DLC has Reported Licensing Concerns to the State of Utah for Nearly a Decade Without Systemic Change in Agency Actions[53]

### A. Intermediate Care Facilities

For almost ten years, the state of Utah has failed to appropriately address repeated, serious complaints about the abuse and neglect of individuals in intermediate care facilities (ICF). The DLC's efforts to advocate for safe conditions in ICFs have included raising concerns of abuse and neglect with DHHS officials in meetings, multiple letters to DHHS about facility conditions, monitoring of and alerting DHHS of ICF deaths, two DLC published reports sent to DHHS, a report created by an expert witness given to DHHS, information provided to the legislature and a class action *Olmstead* lawsuit. Additionally, the Utah State University Center for Excellence in Developmental Disabilities Education, Research, and Service (UCEDD) recently sent an email to DHHS documenting similar concerns regarding abuse and neglect in ICFs based on its own observations of conditions, independent of the DLC's monitoring work.[54]

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relating to the provision of health care and social services." 28 C.F.R. § 35.190(b)(3). Section 1557 of the Patient Protection and Affordable Care Act prohibits discrimination on the grounds of race, color, national origin (including LEP), sex, age, or disability in any health program or activity that receives Federal financial assistance from HHS or is administered by HHS. 42 U.S.C. § 18116.

[50] *Id.*

[51] 28 C.F.R. § 35.130(b)(3)(i); 28 C.F.R. § 41.51(b)(3).

[52] 42 U.S.C. § 12132; 29 U.S.C. § 794.

[53] While this complaint focuses on LTC facilities governed by federal regulations, we are also concerned by DHHS's failures to protect individuals in state-regulated facilities like Youth Residential Treatment Facilities (YRTFs) and Assisted Living Facilities (ALFs). These concerns are documented in both the DLC's COVID report and Licensing report discussed herein. *See* Disability L. Ctr., THE LICENSE TO MISMANAGE: INVESTIGATING UTAH'S TROUBLED LONG-TERM CARE SYSTEM (2023), https://disabilitylawcenter.org/wp-content/uploads/2023/06/DLC_The-License-to-Mismanage_draft-4a.pdf; Disability L. Ctr., The Dangers of Inst. Living, *supra,* note 43.

[54] Document on file with the DLC.

Beginning in 2014, the DLC received numerous complaints about the state run ICF, the Utah State Developmental Center (USDC). The DLC investigated and substantiated complaints of abuse and neglect, including egregious harm such as multiple sexual assaults. The DLC brought these concerns to DHHS and outlined its obligations to enforce Federal licensing requirements.[55] Yet, DHHS failed to take appropriate measures to protect USDC residents from further harm.[56] The DLC elevated its concerns through a systemic complaint to the regional CMS office. Using its look back authority CMS conducted an on the ground survey and substantiated 12 out of 13 alleged violations. Unfortunately for its residents, USDC has again received attention for abuse and neglect after a staff member was arrested in February of this year for allegedly sexually assaulting a resident.[57]

In 2018, the DLC filed an *Olmstead* class action lawsuit against the state on behalf of people with intellectual disabilities residing in private ICFs. The DLC's complaint documents serious safety concerns and harmful conditions in these facilities after years of extensive monitoring. The DLC has continued to raise health and safety problems in ICFs with DHHS over the past 6 years, including numerous letters, meetings with state survey officials, and providing information to the state legislature.

Under the DLC's access authority, our agency receives monthly reports from DHHS documenting the deaths in ICFs. When the DLC initially requested this information in September 2020,[58] DHHS responded that no department agency collects that information nor is there a fatality review of deaths in private ICFs. The DLC began receiving ICF cause of death reports from DHHS in March 2021. Through these monthly reports, the DLC has observed certain ICFs with an alarming pattern of deaths. Yet, these deaths were not caught by DHHS due to a lack of a fatality tracking and review process.[59]

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[55] 42 U.S.C. § 1395aa.

[56] During one meeting to discuss the ongoing sexual assaults, a state official expressed an inability to ensure the safety of USDC residents by asking how many sexual assaults would be acceptable to the DLC. This question, while crude and inappropriate, demonstrated the need to elevate the DLC's concerns to CMS for corrective action.

[57] Kayla Winn, *American Fork Caregiver Arrested on Sexual Abuse Charges Against Disabled Patient,* KUTV (Feb. 28, 2024) https://kutv.com/news/local/american-fork-caregiver-arrested-on-sexual-abuse-charges-against-disabled-patient-20-year-old-jarod-squire-highland-utah-inappropriate-sexual-activities.

[58] The DLC was already receiving reports regarding COVID-19 infections and deaths in all long-term care facilities, starting in April 2020; these reports included COVID-19 infections and deaths in ICFs, but not other deaths in ICFs.

[59] Individuals residing in ICFs are not generally at risk of death and these numbers appeared unusual given the causes that were given. A cluster of deaths caused by septic shock can indicate a lack of medical care; multiple deaths due to aspiration or choking can indicate understaffing or neglect; deaths due to a traumatic head injury or blunt force trauma can indicate abuse.

Some examples of concerning deaths between 2018 and present day in these facilities include the following:

- ICF A: Three individuals have died from aspiration, two individuals died from septic shock and one person died of malnutrition;
- ICF B: One individual died from choking, one individual died from malnutrition, one individual died from sepsis and two individuals died from aspiration;
- ICF C: One person died from a traumatic head injury and one person died from sepsis;
- ICF D: Six individuals have died from aspiration pneumonia.[60]

After reviewing the ages and cause of death in the monthly report, the DLC identified the death of a 12-year-old girl who passed away in November 2021 from sepsis due to a kidney infection. A former staff member told the girl's mother that the facility was constantly understaffed, including nursing staff, and that direct care staff came to work intoxicated. Staff described the daughter screaming in pain in the time leading up to her death. These signs were not acted upon, and when the young girl was moved to the hospital nothing could be done to stop the infection. State survey records reviewed from before and after the death show there was no investigation and no action taken against the facility. Even though it was clear from the young girl's age and manner of death that the facility should have been questioned about the circumstances that led to her death.[61]

In February 2022, a 64-year-old woman died from an upper airway obstruction in the same facility. The woman was supposed to be monitored while eating but was left unattended and choked over several days before she died. The facility was issued a $200 civil monetary penalty and given a conditional license yet was found to be in substantial compliance soon after. Even after two concerning deaths in a three-month period, the State permitted the facility to operate until the ICF voluntarily relinquished its license in a bed-purchase agreement with the State in 2023.

In June 2023, the DLC issued a report "The License to Mismanage"[62] which outlined the systemic failures of Utah DHHS to address health and safety concerns across the LTSS system. As referenced above, the report details the death of Chien Nguyen, a person with severe and persistent mental illness. Chien resided in Evergreen Place, an unlicensed boarding home long known to DHHS to have deplorable conditions including no heat, standing sewage, and a severe bedbug infestation. Even with complaints to

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[60] ICF Cause of Death Reports, documents on file with the DLC.

[61] Aside from the staff member's report, the details in the DHHS report should have raised concerns for the state. Death from a kidney infection raises the concern of unchanged briefs. A common red flag for understaffing includes higher rates of urinary tract infections, which if left untreated, can cause severe complications. Even though DHHS may have been unaware of a young child's death, the details surrounding her death were later provided to the state.

[62] LICENSE TO MISMANAGE, *supra* note 53.

DHHS about the ongoing conditions, the State did not act to address them. Instead, it was the county sheriff's department and the county health department that finally shut the facility down.

Due to a lack of community mental health residential options, Chien was placed at Hidden Hollow, an ICF with a poor record of patient care. This was unexpected given that Hidden Hollow was licensed to serve only individuals with intellectual and developmental disabilities, not severe and persistent mental health illness. Chien had no record of intellectual and developmental disabilities, but he did have language access needs. Chien primarily spoke Vietnamese; his assessments state that he had a language barrier and his records document that he was unable to converse with other residents. With the exception of a psychological assessment conducted in 2022, there is no indication that Chien's language needs were addressed or incorporated into his care by providers or state and local government agencies. After moving to Hidden Hollow, Chien no longer had access to his mental health providers, faced delays in accessing his medication, and began to experience more serious psychiatric symptoms, including suicidal ideation. Records and interviews demonstrate that Chien went one to two weeks without his psychotropic medications including Clozaril, a psychotropic medication that alleviates suicidality in people with schizoaffective disorder. The ICF did not create a care or behavior support plan during this time, despite this increase in behaviors and suicidal ideation. Chien attempted suicide by running into the busy street and lying down on the day of April 10, 2022, but no additional precautions were taken at that time, and the administrator present did not notify anyone of the attempt, including night staff. Early the next morning on April 11, 2022, Chien died by suicide after running out in front of the vehicle of a Hidden Hollow staff member who was leaving while on-shift to get food, resulting in only one staff member as the sole caretaker for approximately thirty-two individuals.[63]

When Chien died in April 2022, Hidden Hollow was given a status of immediate jeopardy and a fine of $8,000. However, the $8,000 fine was not solely attributable to Chien's death and covered an incident where Hidden Hollow staff physically assaulted a resident resulting in a broken tooth. Hidden Hollow's conditional license was lifted a mere month later without clear indicators of remediation or change in the record. It was not until

[63] Correct staffing is calculated over a 24-hour period; during the third shift Hidden Hollow should have had at least one staff member per 16 individuals according to staffing minimum requirements 42 C.F.R. § 483.430(d)(3); Ctrs. for Medicare & Medicaid Servs., State Operations Manual, App. J, W187 (2018), https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/som107ap_j_intermcare.pdf. However, the facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans, defined as enough care staff to meet client needs and respond to emergencies. 42 C.F.R. § 483.430(d)(1) and guidance.

there was significant press coverage of the DLC's report in June of 2023 that Hidden Hollow's license was revoked by DHHS resulting in an immediate closure of the facility.[64]

### B. Nursing Facilities

In 2021, the DLC published a report The Dangers of Institutional Living: COVID-19 in Utah's Long-term Care Facilities.[65] The report documented how a lack of oversight in long-term care settings contributed to an incredible loss of life and worsening facility conditions. During the pandemic, DHHS selected nursing facilities that had a history of problematic surveys and high rates of COVID infection and death to serve as COVID-19 designated facilities [66] These designations were made even in the face of requirements that facilities serving as COVID-19 designated facilities were supposed to be in good standing and demonstrate that they could effectively isolate COVID positive patients.[67] DHHS defied requirements and funneled many of the most vulnerable to settings known to have problematic histories and high COVID-19 death rates. For example, Sandy Health and Rehabilitation had 73 deaths from COVID-19, which was the highest number of deaths in a nursing home in Utah (as reported at of the time of the publication.)[68] The facility also had a history of poor care prior to the pandemic, including a resident with diabetes who was found unresponsive after her blood sugar had not been checked for six days. During the pandemic, surveyors documented facility staff failing to answer call lights and ignoring residents who verbally cried out for help.

The DLC alerted DHHS to our concerns about Sandy Health and Rehabilitation in its COVID report and discussed these issues with DHHS. DHHS denied these concerns, and the facility showed a sustained pattern of noncompliance through the state survey process documenting abuse and neglect, filthy conditions, and a misappropriation of resident belongings. Sandy Health and Rehabilitation's ongoing problems have resulted

[64] Paighten Harkins, *Utah Care Center Shut Down by State Sues, Argues No 'Imminent Threat' to Public,* THE SALT LAKE TRIB. (July 20, 2023), https://www.sltrib.com/news/2023/07/20/utah-care-center-shut-down-by/; Arielle Harrison, *State Urged to Continue Making Progress After Revoking Licenses of Two Care Facilities,* KUTV (July 24, 2023) https://kutv.com/news/local/state-urged-to-continue-making-progress-after-revoking-licenses-of-two-care-facilities-diamond-ranch-hidden-hollow.

[65] THE DANGERS OF INST. LIVING, *supra* note 43.

[66] *Id.*

[67] Coronavirus, Utah.gov, available at https://coronavirus.utah.gov/recommendations-for-providers/ (accessed February 2022).

[68] These numbers were pulled from federal data collected by CMS from long-term care facilities during the Covid-19 pandemic. DHHS officials dispute the number of deaths reported by CMS at Sandy Health and Rehab as reporting errors and that the numbers are far lower. Information publicly available from CMS; data pulled from STARPRO Analyzer program on file with DLC.

in the facility being placed on the Special Focus Facility candidate list, which perhaps could have been avoided with earlier intervention from DHHS.[69]

## IV. Continuing Systemic Failures to Protect Long-Term Care Residents

### A. DHHS Knowingly Spends Federal Dollars on Unsafe Providers

By its own admission, DHHS allows individuals to remain in unsafe facilities funded with federal dollars because there is nowhere for people to go otherwise.[70] In DHHS' response to the DLC's June 2023 report, The License to Mismanage, DHHS asserts,

> The state must navigate a balance: Ensure there are safe places for individuals to be cared for and that enough private programs remain available for these individuals to live. When our department fails to strike that balance, we risk reacting too quickly to close a program without a safe placement for individuals in that program to live. In many cases, they can't simply go home. Who would care for these individuals? Where would they go?[71]

When asked by a reporter, "Is there a follow-through process on the part of OL [Office of Licensing] to make sure a facility does what they're supposed to do, or is it simply the honor system?" DHHS agency staff states,

> I don't think he's realizing that even with a license we would have been out there maybe once a year announced [...] Can I just say 'It's on the honor system. We encourage any member of the public, or organization placing an individual in a care facility to check for proper licensure.' [...] we aren't a health enforcement agency [...] Maybe add your language that we aren't a health enforcement agency? [...] It is not standard practice that we let facilities operate without a license. [...] They were notified they needed to have a license. [...] But do we have a follow through process? [...] not in rule really, but we should have.[72]

When a state representative questioned DHHS' reluctance to shut down Highland Ridge, DHHS responded, "[I]f they shut this place down – which they'd like to do – there's not

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[69] Ctrs. for Medicare & Medicaid Servs., Special Focus Facility (SFF) Program (2024), https://www.cms.gov/files/document/sffpostingwithcandidatelist-january2024.pdf-0.

[70] The Social Security Act mandates the establishment of minimum health and safety and CLIA standards that must be met by providers and suppliers participating in the Medicare and Medicaid programs. Ctrs. for Medicare & Medicaid Servs., State Operations Manual, ch. 1 § 1000, https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/som107c01pdf.pdf. Section 1864(a) of the Act directs the Secretary to use the help of State health agencies or other appropriate agencies when determining whether health care entities meet Federal standards. *Id.* at § 1002.

[71] Gruber, *supra* note 14.

[72] Internal communication by DHHS staff, document on file with the DLC.

space to take these patients."[73] The lack of alternative settings, including community based settings is a failure by DHHS to meet its obligations under the Medicaid Act and non-discrimination provisions, not a reason to keep people in dangerous settings.

In addition to the other examples provided, DHHS has allowed Primary Support Services (PSS), an extremely dangerous Home and Community Based Services (HCBS) Community Supports Waiver provider, to continue to operate funded by federal dollars. To be granted an HCBS waiver, states are required to provide assurances that necessary safeguards have been taken to ensure the health and welfare of beneficiaries.[74] States that fail to do so may have their waiver terminated.[75] DHHS was well aware of a pattern of harm by PSS over a span of years: in May 2020, PSS staff lost an individual for 48 hours; in October 2020, the owner of PSS took another individual to her home and her husband restrained the individual by sitting on him resulting in injuries; in November 2022, an individual was found in Las Vegas by law enforcement and returned to Utah (in this case PSS had not reported the person as missing and it is unclear how long he was missing for; however, Las Vegas is hundreds of miles away from the individual's residence in Draper, Utah ). DHHS did not engage in effective oversight during this time period despite a pattern of harm to individuals in PSS services.[76] Rather, licensing placed PSS' foster care license on conditional status on September 1, 2022, issued a foster care license revocation in January 2023, but then again placed the foster care license on conditional status on February 2, 2023.[77] On January 31, 2023, DHHS Office of Service Review (OSR) issued a suspension of PSS' contract, which appears to have been quickly reinstated. There is no indication in the DHHS records reviewed that the foster agency licensing and contract actions triggered a review of other waivers services provided by the entity.

On May 23, 2023, a 15-year-old in PSS residential services who had assaulted his roommate and staff, and threatened to kill a person in the community, eloped and was found by police. The day after, on May 24, 2023, DHHS issued a cease-and-desist order to PSS for operating its day program while unlicensed and issued a $500 civil monetary

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[73] Herberts, *supra* note 17.
[74] 42 U.S.C. § 1396n(c)(2)(A); 42 C.F.R § 441.302(a).
[75] 42 C.F.R § 441.302.
[76] Multiple reviews conducted by the Office of Service Review (OSR is an office under the Operations Section at DHHS) during this time period show the provider had issues with training and background checks of staff, documentation and implementation of care plans. In each instance, OSR required a plan of correction which PSS was found to have quickly complied with. Reviews on file with the DLC.
[77] PSS was required to have a Child Placing Foster License as it provided residential services to minor waiver participants. Based on DHHS rules, PSS adult residential services likely do not require licensure, only certification, as they housed 3 or less participants. Based on record review, these actions seem based on PSS issues with background screening, critical incident reporting and fulfilling home study requirements.

penalty. PSS continued to operate and bill Medicaid for day services while not licensed and continued to provide residential services.[78] During this time, unbeknownst to guardians and not in accordance with care plans, PSS stopped serving clients at a brick-and-mortar day program and allowed employees to haphazardly take individuals wherever the employee decided.[79] In July 2023, a PSS employee took an autistic individual who is non-speaking and has significant support needs to her home and then lost the individual. The employee is alleged to have lied to the individual's guardians and law enforcement about where the individual was lost, resulting in a delay of the individual being found. The individual was missing overnight during a summer heatwave and was found injured, without shoes or a shirt. DLC staff along with the individual's case manager immediately notified DHHS agencies of the abuse and neglect incident and urged the agency to take swift action because individuals served by PSS were in imminent danger. PSS should have been under closer scrutiny by DHHS during this time because of the many critical incidents known to DHHS, the shutdown of the PSS foster care agency by DHHS, and DHHS knowledge that PSS was continuing to operate an unlicensed day program; this oversight failure resulted in serious harm to an individual in services. However, DHHS did not shut down the PSS day program permanently until September 16, 2023.

The PSS owner continued to operate a day program after September 16, 2023, under a different provider name and other providers related to PSS were allowed to continue to operate without further investigation of their practices even with the connections to PSS. Additionally, PSS residential services continued until November 1, 2023 without sufficient additional oversight. DHHS records demonstrate that individuals in PSS residential services were neglected after the day program shutdown; money was taken from residents by the PSS owner, individuals did not have adequate food or electricity and that rent, and staff, went unpaid for months.

One of the individuals harmed by this DHHS failure was Malachi Portwood, a 16-year-old with autism and significant support needs. Malachi was known to elope from his residence and had a history of stealing cars. In October 2023, Malachi was discharged

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[78] DHHS records state, "[PSS owner] now knows that they should have turned clients away who only get DSG [Day Supports Group] from PSS once their license was revoked but that they were initially confused at the end of May when it happened and how they could continue forward (Licensing states they cleared up the confusion by the first week of June.)" Document on file with DLC.

[79] Day programs must "ensure that community-based services are provided safely and in consideration of weather, transportation, emergencies and overall client needs for food, medicine and any other assistance necessary for safe participation in the program." Utah Admin. Code § R501-20-8(5). Day programs are also required to supervise clients and maintain supporting documentation as determined by a person-centered service plan or behavior support plan. Utah Admin. Code § R501-20-8(4)(b)(i)–(vii); 42 CFR 441.301(c

from PSS to a provider related to PSS, Future Rising. Future Rising retained all PSS staff and operated at the same sites that PSS had.[80] Malachi had a very large waiver budget, approximately $400,000, and his care plan included a significant number of supports to address his elopement and car theft behaviors, including 24/7 awake staff and door/window alarms. DHHS records document that neither PSS nor Future Rising implemented the measures required by Malachi's care plan. Additionally, records show that both during the time PSS and Futures Rising were Malachi's residential provider, Malachi had no hot water, electricity was off, rooms were uncleaned and there was a severe bed bug infestation. Records also state that staff did not have the appropriate background checks on file.[81]

On November 1, 2023, while his staff slept and there were no alarms on his doors or windows (as were required by his care plan), Malachi eloped and stole a city water tank vehicle, then stole a truck and crashed it, and then attempted to steal an ATV. These incidents resulted in criminal charges and Malachi was returned home on the condition of the court that he would have 24-hour awake staffing and precautions including door and window alarms. Futures Rising did not implement these precautions required by the judge and Malachi's person-centered support plan. On the night of November 9, 2023, while Malachi's staff slept, Malachi left his residence and stole a vehicle. Records demonstrate that while Malachi's staff and the administrators at both PSS and Future Rising knew Malachi had eloped, they delayed calling the police and worked to cover up what had happened. Malachi, his disabilities, and his history of elopement and penchant for stealing vehicles were all well known to local police. While driving the stolen vehicle, Malachi seriously injured a motorcyclist, causing the motorcyclist to have both legs amputated. Police attempted to stop the vehicle by shooting at Malachi, resulting in his death.[82] Local police were familiar with Malachi, and it is likely that had they been informed of his elopement he would not have been shot. To date, Future Rising continues to operate and has only been assessed a $500 penalty for the events surrounding Malachi's death.

Records demonstrate that PSS frequently has served individuals with very high support needs and large budgets, yet DHHS allowed PSS to operate despite years of harm to waiver participants and failures to implement services according to plans of care. Insufficient DHHS monitoring enabled the provider to continue providing day services

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[80] Additionally, an internet search demonstrates that administrators at PSS and Future Rising are relatives. Also, Futures Rising employed an individual who owned a foster agency that had recently had its license revoked. DHHS staff could have easily found this connection had it investigated and exercised appropriate oversight of PSS and its closure, and the placement of PSS residents.

[81] All direct care staff working with clients must pass an annual background screening. Utah Code Ann. § 62A-21-120(5); Utah Admin. Code § R501-14-3.

[82] Jordan Miller, *Teen Fatally Shot by Sandy Police Veered Van Toward Officer, Bodycam Shows,* THE SALT LAKE TRIB. (Nov. 22, 2023) https://www.sltrib.com/news/2023/11/22/teen-fatally-shot-by-sandy-police/.

while unlicensed, resulting in the near death of an individual in July 2023. DHHS also failed to monitor PSS residential services after the agency fully closed day services, failed to ensure that PSS residents were appropriately discharged to a safe provider, and failed to conduct competent investigations to ensure that administrators associated with PSS were not continuing to operate.

DHHS internal communication also shows the agency knew Malachi was in danger and failed to act. On August 11, 2023, an agency constituent services employee emailed the waiver quality division within DHHS with her concerns about PSS and Malachi's safety. Additionally, this employee also emailed DSPD administrators on 3 occasions, August 18, 2023, September 12, 2023, and November 2, 2023, with concerns about Malachi's safety due to his elopements and the instability of his provider, including concerns that incident reports were not being submitted. On November 2, 2023, Malachi's case manager notified the agency that Malachi stole a city water truck and a van and then attempted to steal a four-wheeler. The agency took no substantive action. Rather, the day before Malachi died on November 8, 2023, an agency administrator asked "Just for my learning, to what extent do these kinds of situations get escalated above us for situational awareness? I am not suggesting a need to do so; just wondering our precedent." The next day on November 9, 2023, the day Malachi died, another agency administrator responded that they could use a weekly briefing sheet and an eligibility/appeal worksheet to escalate the situation: "[w]e have used the Healthcare Admin Section (DSPD) Weekly Briefing Sheet Top Items of Interest to report high risk situations. We also have a spreadsheet for eligibility and appeal issues that EDO has access to."[83]

Sadly, had DHHS taken appropriate action to protect individuals being served by PSS and associated providers, Malachi likely would be alive today. Utah is violating federal requirements by failing to assure safeguards for health and welfare, assure adequate standards for waiver providers and assurances that licensure requirements have been met.[84] DHHS is also failing to assure that service plans address all assessed needs and goals, and that services are delivered in accordance with the service plan.[85] DHHS has also received federal funds to perform monitor and compliance functions it failed to perform. CMS has the authority to terminate the waiver based on these failures and take other corrective action.[86]

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[83] Documents on file with the DLC.
[84] 42 C.F.R § 441.302.
[85] *Id.*; *see also, e.g.,* Ctrs. for Medicare & Medicaid Servs., Modifications to Quality Measures and Reporting in § 1915(c) Home and Community –Based Waivers 3 (Mar. 12, 2014), https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/3-cmcs-quality-memo-narrative_0_2.pdf.
[86] 42 C.F.R. § 441.302.

## B. DHHS' Lax Licensing of New Providers Endangers Individuals

The process to become a licensed Utah LTSS provider is insufficiently rigorous to ensure the safety of people with disabilities and older adults. Utah DHHS is failing to assure qualified providers, as well as health and welfare, thereby violating the federal requirements for operating Medicaid waivers.[87] On the basis of failing to provide these assurances, CMS can refuse to grant a waiver and may terminate a waiver already granted and may also take other corrective actions.[88]

Providers that have closed due to resident harm are permitted to reopen under different names with the same owners/staff and at the same locations. After the PSS day program was shut down, the owner of PSS was able to open as two new day program providers, Wasatch Special Care[89] and Cornerstone.[90] Future Rising was able to take over the PSS residential sites using the same PSS locations and employees while employing an individual who is a relative of the owner of PSS (who also had a revoked foster care agency license). Future Rising was able to self-attest that the settings formerly owned by PSS were fully in compliance with requirements of federal rules on October 10, 2023, without verification by DHHS;[91] DHHS records show that at least one of these settings had deplorable conditions at the time of the self-attestation.[92] DHHS appears to not even take perfunctory measures to ensure that federal dollars are not spent on known dangerous providers; all of these connections between newly-opened providers and providers that had been shut down for endangering clients can be made using internet searches and reviewing DHHS' own records. PSS affiliated programs operate to this day and the DLC continues to receive complaints on nearly a weekly basis.

A recent state legislative audit of a DHHS division documented a lack of oversight of the process to become a HCBS provider. Auditors cited multiple issues with provider

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[87] *Id.*
[88] *Id.*
[89] As of the day of this complaint, Wasatch Special Care remains on this list of providers on the DSPD "Find a Provider" website, https://dspd.utah.gov/resources/find-a-provider/. The registered business agent of Wasatch is a relative of the owner of PSS. Additionally, the owner of PSS represented herself as an employee of Wasatch at Malachi Portwood's person centered planning meeting.
[90] A google search shows that the physical location of Cornerstone is the former location of PSS. A former PSS administrator is listed as a manager on Cornerstone business filings. The husband of the former PSS administrator is listed as a Cornerstone administrator on his LinkedIn profile.
[91] Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers, 79 Fed. Reg. 2948 (Jan. 16, 2014), http://www.gpo.gov/fdsys/pkg/FR-2014-01-16/pdf/2014-00487.pdf. The HCBS "Settings Rule" requires that individuals in waiver services are free from coercion and restraint, among other requirements that ensure autonomy and community integration..
[92] Records on file with the DLC.

licensing and compliance, relating that some providers were unaware that they are Medicaid providers and were unfamiliar with the regulations that apply to Medicaid providers.[93] Additionally, agency staff incorrectly described the federal HCBS settings rule and directed new providers who had yet to fulfill the requirements of the rule to attest that they were already in compliance.[94] Auditors found it problematic that all of the provider related DSPD policies go to the state provider organization first and that "[I]t appears that the process may be working backward in this instance and may have contributed to the areas of non-compliance with Medicaid policies and regulations."[95] Providers themselves have reported concerns to the DLC that the requirements to become a provider are insufficient to ensure that individuals in services are safe. other

Moreover, the implementation of DHHS' background check system is insufficient to ensure the safety of individuals in services. Utah Code requires an initial background check and ongoing monitoring.[96] For healthcare facilities, providers are required to run a verification report annually.[97] Human services providers are required to check on a monthly basis.[98] If DHHS determines that an individual is not eligible for direct patient access, the department should send a notice of agency action disqualifying the individual from continuing to work with vulnerable individuals.[99] Providers assert that contrary to state rules, DHHS does not consistently notify providers of a disqualifying background finding during the ongoing background monitoring process. For example, a provider employee was arrested for murder but the provider was not notified by DHHS and only discovered the charges when the employee was arrested at the residential long-term care setting.

### C. DHHS Lacks Adequate Staffing & Resources

The DHHS licensure agency is understaffed. It also fails to engage in appropriate investigations of abuse and neglect in long-term care facilities. A recent study ranked Utah 51st in the nation after examining elder abuse, elder fraud, abuse prevention, long-

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[93] Utah Office of the Inspector General, Medicaid Waiver Utilization, Medicaid Service Documentation, and Medicaid Records Retention Practices by DSPD and DSPD Providers, Report No. 201-01, 2019-05, 65 (Sept. 28, 2022), (describing the DSPD billing process under which providers would bill DSPD and then DSPD billed Medicaid, leaving providers unclear they were providing Medicaid-funded services).
[94] *Id.* at 54. Since the audit release the state has added a self-assessment requirement in addition to the self-attestation clause that providers were directed to attest to.
[95] Utah Office of the Inspector Gen., Medical Waivers Utilization, Medical Service Documentation, Medical Records Retention Practices by DSPD and DSPD Providers 35 (Sept. 28, 2022) https://oig.utah.gov/wp-content/uploads/Medicaid-Waivers-Utilization-Medicaid-Service-Documentation-Medicaid-Records-Retention-Practices-by-DSPD-DSPD-Providers.pdf.
[96] Utah Code Ann. § 26-B-120.
[97] Utah Admin. Code § R432-35-4(9).
[98] Utah Admin. Code § R501-14-4.
[99] Utah Admin. Code § R-432-35-4.

term care, nursing home quality, and shelters across all 50 states and the District of Columbia.[100] A U.S. Senate report released in May 2023 states that oversight agencies across the country, including Utah DHHS, lack the resources to adequately "respond in a timely manner when residents and families file health and safety complaints."[101] Twenty-five percent of surveyor positions are unfilled in Utah,[102] and 60% of surveyors have two or less years of experience.[103]

A presentation by DHHS Licensing during the 2024 legislative session connects Utah's lack of licensing staff with higher health and safety risks to individuals in long-term care.[104] Utah DHHS cited a 45% increase in complaints over the past three years as contributing to a backlog of facility inspections. DHHS states that average rule noncompliance per facility has nearly tripled since 2021.[105] Utah's state budget shows insufficient investment in licensing staff; Utah's licensing budget was $18,806,700 for fiscal year 2024 including 146 licensing staff.[106] These staff cover 1,157 long-term care facilities as well as all childcare centers in the state, approximately.[107] By comparison, Utah has 14 times the number of long-term care facilities as Idaho, a similarly situated western state, but only twice the number of licensing staff.[108] This disparity is especially problematic given that Utah has over 100 YRTFs housing vulnerable children from all

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[100] Derick Fox, *Utah is the Worst State for Elder Care, According to a New Study,* ABC4 (Dec. 14, 2022) https://www.abc4.com/news/local-news/utah-is-the-worst-state-for-elder-care-according-to-a-new-study/.
[101] PRTF Senate Report, *supra* note 28.
[102] *Id.* at 79.
[103] *Id*.
[104] Utah Division of Licensing & Background Checks, DHHS Budget Request: Health Facility Licensing Staff (2024), *available at* https://le.utah.gov/interim/2024/pdf/00000217.pdf.
[105] *Id.*
[106] *See* Utah Dep't. of Health & Hum. Servs., *DLBC Org. Chart*, May 2024, https://dlbc.utah.gov/wp-content/uploads/02.2024-DLBC-Org-Chart.pdf (citing $5,440,400 of the appropriations amount was from federal funds. $14,479,300 was appropriated specifically for personnel); *Licensing & Background Checks: Appropriation History by Funding Source*, Utah State Legis., https://cobi.utah.gov/2024/3611/financials (last visited 7/2/2024)
[107] *See DLBC Org. Chart*, *supra* note 106; Utah Dep't. of Health & Hum. Servs., Office of Licensing Staff Funding Request (2024), https://le.utah.gov/interim/2024/pdf/00000217.pdf.
[108] Compared to Utah, Idaho has a population of 1.4 million fewer people and only approximately 82 facilities overseen by 72 licensing staff with a budget of $8,064,200. *See* Idaho Dep't. of Health and Welfare, Idaho Leg. Budget Book, 2022 Leg. Sess., at 57 (2022), https://legislature.idaho.gov/wp-content/uploads/budget/JFAC/sessionrecord/2022/3.Health%20and%20Human%20Services/Health%20and%20Welfare,%20Department%20of/LBB.pdf; Idaho Dep't. of Health and Welfare, Long-term Care/Skilled Nursing Facility (2020), https://healthandwelfare.idaho.gov/sites/default/files/2020-08/Facilities%20-%20Long%20Term%20Care.pdf.

over the United States.[109] A newly released U.S. Senate committee report on a two year study of youth residential treatment facilities urges states to improve oversight given the findings that ”abuse and neglect is the norm” in these facilities with children routinely experiencing harm including sexual abuse, seclusion and restraint amounting to ”taxpayer funded child abuse” which ”reads like something from a horror novel.”[110]

**D. DHHS Conducts Inadequate Investigations**

DHHS fails to appropriately investigate serious allegations of abuse and neglect. As a particularly egregious example, in 2022 the DLC and DHHS received an anonymous letter alleging widespread abuse and neglect at an ICF. The author of the letter claimed to be a former staff member of the facility. The letter included allegations of verbal, physical and financial abuse, consistent understaffing, forcing people to go without incontinence briefs at night, and sleep deprivation.

Concerned, DLC staff along with an expert witness visited the facility in the spring of 2023 to conduct an investigation and uncovered evidence of abuse. DLC staff documented accounts from staff members of an employment provider that served many of the ICF residents, that individuals would show up to the program exhausted. Program staff also observed bruising on residents, open sores, and black eyes and when the ICF facility administrator was questioned replied “don’t worry about it.”

The DLC also confirmed through staff interviews that residents were not allowed to use incontinence briefs at night and instead were woken multiple times throughout the night and checked for signs of wetness. If a resident had been incontinent, they were forced to clean and replace their bedding as well as shower themselves before they were permitted to go back to sleep.[111] Residents reported feelings of distress and humiliation around this practice during interviews with the DLC. These reactions, along with the observations from the day program, are consistent with ongoing sleep deprivation. When the DLC shared its investigation and expert findings with the DHHS, the department responded that they were aware of this practice but did not consider these actions to

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[109] Ayesha Rascoe, *The Youth Treatment Industry Booms in Utah, but Has Skirted Reform for Years, All Things Considered,* NPR (Mar. 27, 2022), https://www.npr.org/2022/03/27/1089047752/the-youth-treatment-industry-booms-in-utah-but-has-skirted-reform-for-years (finding “Utah is the epicenter of America’s teen treatment industry” and that Utah’s regulatory system “historically has been really lax and friendly towards this industry as a whole.”)

[110] Jessica Miller, *’Taxpayer-funded Child Abuse’: What a Congressional Investigation Found Happens at Youth Treatment Centers in Utah and Across the Country,* THE SALT LAKE TRIB. (June 13, 2024), https://www.sltrib.com/news/2024/06/13/taxpayer-funded-child-abuse-what/.

[111] Additionally, the DLC substantiated claims related to interference with its ICF *Olmstead* settlement with the state wherein administrators engaged in substantial discouragement to individuals wishing to leave the ICF under the settlement, to the extent of helping staff members and relatives of staff members, as well as family members of residents to gain guardianship over individuals.

constitute abuse or neglect. The DLC presented evidence that residents were constantly sleep deprived due to frequent awakenings throughout the night, which is a serious harm to their physical and behavioral health. DLC staff also included a declaration from a consulting expert testifying that the facility's nighttime toileting practices were not an acceptable form of care, but DHHS took no action and to our knowledge did not conduct an unannounced nighttime survey to independently observe the practices and the effects on individuals.

The 2022 anonymous letter also alleged that residents were being showered by members of the opposite sex in a manner that made them uncomfortable. State survey investigated the allegation but found there was no evidence to substantiate the claim. Records from 2022 showed that the director of APS warned the facility that these practices could lead to serious allegations in the future. During the DLC's 2023 investigation we conducted interviews with a parent who alleged their adult child voluntarily left the facility after being sexually assaulted in the shower. To our knowledge, there was no complaint survey investigation conducted after we reported this incident. Then again in the fall of 2023, a second resident alleged they had been assaulted in the shower and DHHS was unable to substantiate the report and no deficiencies were cited. Adult Protective Services (APS) eventually substantiated the allegations and during staff interviews the administrator of the facility told the investigator that the Office of Licensing had already determined the allegations were unsubstantiated.

A review of the facility survey records also raised concerns about possible abusive practices that state survey staff were missing. For example, surveyors were told by facility staff that individuals were being physically restrained in a four-point hold on their hands and knees. Typically, four-point holds involve restraining someone's arms and legs and are not implemented while an individual is on their hands and knees. This should have signaled to the surveyor to inquire as to why this unusual type of restraint was necessary, if there had been a behavioral needs assessment, if staff had been appropriately trained, and if there was appropriate data collection to support its continued use. Facility staff also told the DLC that they frequently use prone restraints and place a cloth under an individual's face when utilizing the hold. Prone restraint is well-recognized as dangerous and potentially fatal, not including the use of a face covering which would exacerbate the known issues with prone restraint.[112] For over two years, the DLC repeatedly raised concerns about the facility with the State, and we raised concerns that the Office of

[112] Several state agencies have banned the use of prone restraint because of the known dangers. Several state agencies have banned the use of prone restraint because of the known dangers. *See, e.g.,* Ohio Dep't. of Dev. Disabilities, *Prone Restraint* (Jan. 2019) https://dodd.ohio.gov/wps/wcm/connect/gov/812e91cf-62aa-4ce3-9770-a7134a7235e7/2019%2BWell-Informed%2BProne%2BRestraint.pdf.; Disability Rights N.C., *Disability Rights N.C.: An Introduction* (Dec. 8, 2023), https://disabilityrightsnc.org/general/disability-rights-nc-an-introduction.

Licensing's surveys were not sufficient to protect the health and safety of those living in the facility. It was not until 2024 when APS substantiated the allegations of sexual assault (and other physical abuse) that the Office of Licensing took substantial action.

### E. DHHS Fails to Provide Effective Communication and an Accessible Investigation Process to People with Disabilities.

DHHS fails to fully investigate because they do not communicate with individuals with disabilities in the facilities affected by the abuse and neglect. The investigative process is not accessible to all people with disabilities. DHHS staff fail to provide effective communication appropriate to the needs of individuals with disabilities during their investigations as required by federal law.[113] We have spoken to individuals with developmental and intellectual disabilities who made allegations of abuse and neglect to DHHS who were not interviewed or responded to before their complaints were closed as unsubstantiated. In one case, a client had reported inappropriate sexual behavior of a staff member to DHHS but was not interviewed about the allegations and received no response to her report. In another case, DHHS APS closed a case where a waiver participant with a developmental disability and limited communication skills had trouble identifying who had sexually assaulted her when she was interviewed by APS. However, when DLC staff interviewed the individual and accommodated her communication needs by showing her pictures of different staff members, she identified the manager of her day program as the person who had committed the sexual assault.[114]

### F. DHHS Implementation of Enhanced Reimbursement Programs Incentivize Less State Oversight

In Utah, nursing facilities receiving extra funding under a program administered by DHHS called the Nursing Facility Non-State Government Owned UPL demonstrate poor quality of care, including high rates of COVID-19 infection and death during the pandemic. Under the UPL Program, the state Medicaid plan allows local government Medicaid licensees to receive supplemental payments for Medicaid nursing home residents equal to the Medicare rate of $339.69 per day rather than the Medicaid rate of $203.04. These additional funds are substantial and are intended to improve the care at rural nursing facilities. Approximately 70% of all nursing facilities in Utah are UPL facilities and the majority are operated in urban areas; multiple local governments participate in this program, the largest include Beaver Valley with 49 facilities and Gunnison Valley with 7 facilities.[115] However, the facilities owned by these governments are largely not proximate to those localities.

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[113] *See* HHS OCR, *supra* note 49.
[114] The DLC reported this additional information to the agency; it is unknown if the investigation was re-opened. To our knowledge, the manager continues to be employed by the day program.
[115] StarPro Analyzer data on record with the DLC.

Under Utah's UPL program, local governments assume ownership of nursing facilities in name only and the original nursing facility continues to act as the operator. The operator provides an administrative fee to DHHS and "seed funding" to the local government licensee which is equal to 30% of the UPL payment and the remaining funds are given to the operator to be invested in the nursing facility.[116] In 2019, Beaver Valley and its nursing facilities received over $57 million in UPL funds.[117] DHHS charges a sizable administrative fee to the local government licensee. In 2016 DHHS was given $1 million in UPL administration fees.[118] With this payment structure an operator would receive approximately $298.70 per day per resident (after paying 30% of the additional payment to DHHS and the local governmental entity) instead of $203.04 per day resident. The Utah Legislature sought feedback from the National Conference of State Legislatures on UPL programs and was informed that UPL demonstration structures in other states like that found in Utah have been found to be illegal and required paybacks to CMS.[119]

The current UPL program structure and sizable fees retained by DHHS and local governments disincentivizes state oversight of UPL facilities. When the DLC's COVID-19 report was released in 2021, of the 15 nursing homes with the highest deaths in Utah due to COVID-19, 13 were UPL facilities. Of the top 15 nursing facilities with the highest number of deaths as a percentage of confirmed COVID-19 cases, 11 facilities participated in the UPL.[120] In 2020, the Utah Investigative Journalism Project's review of Utah UPL nursing home data found "shocking incidences" of lack of care in these facilities. "A history of poor health inspections and concerns of a lack of oversight [that] been present for years"—23 Beaver Valley facilities had health violations above the national average, including 10 facilities that had more than double the national average of health

[116] *Id.*

[117] Taylor Hartman & Eric S. Peterson, *Utah County Nursing Homes among those Plagued by Health Inspection Violations*, DAILY HERALD (May 20, 2020).

[118] In FY 2016 DOH charged BVH $500,000 as a licensing fee for participating in the UPL program. This fee can be doubled to $1 million dollars with federal funds. John M. Schaff, A PERFORMANCE AUDIT OF THE BEAVER VALLEY HOSPITAL'S MEDICAID UPPER LIMIT PAYMENT PROGRAM PERFORMANCE AUDIT 18 (2017).

[119] Blandford, *supra* note 45.

[120] UPL programs are increasingly being scrutinized for the value they may or may not add to the care of residents in nursing facilities. In 2019, CMS proposed increased regulation of UPL programs stating "We have seen a proliferation of payment arrangements that mask or circumvent the rules where shady recycling schemes drive up taxpayer costs and pervert the system." Maggie Flynn, *Citing 'Shady' Behavior, CMS Proposes Stricter Rules, Time Limit on Medicaid Payment Supplements*, SKILLED NURSING NEWS (Nov. 12, 2019), https://skillednursingnews.com/2019/11/citing-shady-behavior-cms-proposes-stricter-rules-time-limit-on-medicaid-payment-supplements/.

violations.[121] "Five facilities have been the subject of medical malpractice lawsuits since being acquired by Beaver Valley Hospital."[122]

CMS intended the UPL program to improve rural nursing homes through partnerships with local government. CMS envisioned that local governmental entities would have more than token control of nursing homes in UPL arrangements; Utah's UPL structure where a governmental entity like Beaver Valley exercises no oversight or involvement with the operations of a vast number of nursing homes in predominantly urban areas violates the purpose of the UPL program.[123] It is alarming that a program encompassing 70% of nursing facilities in the state, which also generates substantial revenue for local governmental entities, as well as for DHHS, has not resulted in improved care for residents. Rather, individuals residing in a UPL facility were at increased risk for being infected with or dying of COVID-19 during the pandemic, and these facilities have persistent problems with patient care according to state licensing reviews.[124] For all the money DHHS generates from the UPL program as detailed above, it is our understanding that DHHS does not provide increased licensure oversight or conditions monitoring in UPL facilities. The DLC included these concerns about patient care and DHHS' failure to operate the UPL within CMS' intent in its COVID-19 report given to DHHS. DHHS has not addressed these issues and UPL facilities continue to proliferate and provide revenue to DHHS and local governments.

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[121] Hartman & Peterson, *supra* note 117.
[122] *Id.*
[123] Max Blau, *Nursing Home Loophole May Haunt Georgia,* GEORGIA PUBLIC BROADCASTING (Sept. 22, 2020), https://www.gpb.org/news/2020/09/22/nursing-home-loophole-may-haunt-georgia; Taylor Hartman & Eric S. Peterson, *Health Violations Pile Up at Nursing Homes Around the State Owned by Beaver City's Hospital,* THE SALT LAKE TRIB. (May 2, 2020), https://www.sltrib.com/news/politics/2020/05/02/health-violations-pile-up/; Blandford, *supra* note 45; Off. of the Legis. Auditor Gen., State of Utah, *Report to the Utah Legislature: A Performance Audit of the Beaver Valley Hospital's Medicaid Upper Payment Limit Program (For Nursing Facilities)* (Oct. 2017), available at https://le.utah.gov/interim/2017/pdf/00004449.pdf.
[124] *Supra* note 123. Additionally, the Homecare and Hospice Association of Utah (HHAU) has "collected reports of conversations with nursing facility staff and Administrators who have acknowledged that they are not referring Medicaid beneficiaries to hospice services and/or discouraging services until someone is actively dying because it would result in the cessation of UPL payments. Anecdotal family reports have supported concerns of loved ones being encouraged to postpone hospice and try another week of rehabilitation; told that a hospice consultation could be arranged, but there, "might be a billing issue;" or had it explained to them that the facility staff was perfectly capable of doing end of life care, so the patient didn't need hospice." Homecare and Hospice Ass'n of Utah, Upper Payment Limit Program: Collateral Impact on Access to Hospice Servs., https://www.utah.gov/pmn/files/612109.pdf.

## V. Conclusion

Given the serious nature of the concerns described within this complaint, it is our hope that CMS, OIG, and OCR will act quickly to address the significant deficits and misuse of federal funds in Utah's oversight to ensure the safety of all individuals receiving LTSS in the state of Utah.

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