Bridging the Gap: 
Regulatory Compliance in a 
Post Acute Setting 
The Health Care Compliance Association

Objectives
- Current Environment
- OIG’s Regulatory Concerns
  - Skilled Nursing Facilities (SNF)
  - Home Health Agencies (HHA)
  - Hospice
- Compliance Guidance & Risk Areas
- Compliance Pitfalls
- Payment Challenges
- Acute/Post Acute Collaboration
- Partnership Challenges

Current Environment
- CMS provides health care coverage for over 145 million Americans
- Four principal programs
- Annual outlays $1.1 trillion
- Two largest risks
  - Medicare
  - Medicaid
Spectrum of Fraud Waste & Abuse

The Fraud Risk Management Framework

Current Environment

- Spotlight on Skilled Nursing Facilities
  - OIG report – substandard care
    - Failure to meet quality-of-care requirements
    - Incomplete discharge plan
    - Billing for a higher level of care than rendered
  - SNFs – compliance program – effective 11/28/18
Current Environment

- Spotlight on Home Health Agencies
- Growth in Home Health Care Space
- CMS has expanded Target Probe & Educate
- Patient-centered Care
- Patient Rights
- Caregiver Involvement
- Plans of Care
- Discharge Protections
- OASIS-D Changes
- Mis-use of RAPs

Current Environment

- Spotlight on Hospice
- Uninformed consent
- Admitting patients not terminally ill
- Under-utilization
- Forged physician certifications on plans of care
- Insufficient oversight
- Overlap in services with nursing homes
- Billing for higher level of care than necessary
- Since 2016, OIG has revised plans for at least seven different hospice-related audits

Enforcement

- RehabCare Group, Inc. – Ohio – $399,780
- Signature HealthCARE, LLC – Louisville – $30 million
- George Houser (NF owner) – Atlanta – $6.7 million
- More than 400 individuals – 41 federal districts – July 2017 – $1.3 billion in multiple fraudulent billing
  - $141 million false HHA billings
  - 15 individuals HHA & PT fraud
  - $7 million HHA services not rendered
Enforcement

- Chemed Corporation (Vitas Hospice Services) – $75 million – Hospice billing fraud
- Health & Palliative Services – $2.5 million – Hospice billing fraud
- Horizons Hospice – $1.2 million – patients did not have life expectancy < 6 months

https://oig.hhs.gov/fraud/fugitives/profiles.asp#lagoa

OIG Fugitive: Ángel Lagoa

1. In January 2017, Ángel Lagoa was indicted on charges of conspiracy to commit health care fraud and mail fraud. Investigators believe that, from 2010 to 2013, Lagoa and his co-conspirators submitted approximately $140 million in false or fraudulent claims to Medicare.
2. Lagoa owned Three Senior Care, Inc., located in Miami, Florida, and operated it through an entity he owned. This entity, in turn, operated three other entities that claimed to provide home health care services. Lagoa had former paid employees to perform services that were not medically necessary or ordered by a physician.
3. Investigators believe Lagoa is currently residing in Cuba.
Enforcement

OIG workplan:
- Examine SNF nursing staffing levels comply with minimum requirements
- SNF services compliance with required prior 3 day hospital stay
- Medicaid Nursing Home Supplemental payments
- Duplicative and overlapping claims remains a payment concern and OIG initiative for hospice
- Survey and complaint investigations for poorly performing hospices
- Potential abuse or neglect of Medicare beneficiaries
- SNF – Unreported incidents of potential abuse and neglect
- Inappropriate payments for power mobility device equipment
- Determine if home health claims were paid in compliance with Medicare requirements

Seven Elements of a Compliance Program

1. Implementing written policies, procedures, and standards of conduct
2. Designating a compliance officer and compliance committee
3. Conducting effective training & education
4. Developing effective lines of communication
5. Enforcing standards through well publicized disciplinary guidelines
6. Conducting internal monitoring and auditing
7. Responding promptly to detected offenses and developing corrective action
Risk Areas

- **Home Health OIG Compliance Guidance 8/7/1998**
  - Billing for items and services not actually rendered
  - Billing for medically unnecessary services
  - Duplicate billing
  - False cost reports
  - Credit balances
  - HHA incentives to referral sources
  - Billing for visits to patients who do not require a qualifying service
  - Insufficient documentation
  - Falsified plans of care
  - Improper influence over referrals by hospitals who own HHAs

- **Hospice OIG Compliance Guidance 10/05/1999**
  - Uninformed consent to elect the Medicare Hospice Benefit
  - Admitting patients who are not terminally ill
  - Arrangements with another health care provider who hospice knows is submitting claims for services already covered by the Medicare Hospice Benefit
  - Undertime utilization
  - Falsified medical records or plans of care
  - Untimely and/or forged physician certifications on plans of care
  - Hospice incentives to actual or potential referral sources (physicians, nursing homes, hospitals, patients) that may violate anti-kickback statute

- **SNF OIG Compliance Guidance 03/16/2000**
  - Failure to provide appropriate therapy services
  - Failure to provide appropriate services to assist residents with activities of daily living (e.g., feeding, dressing, bathing, etc.)
  - Failure to provide an ongoing activities program to meet the individual needs of all residents
  - Failure to report incidents of overmedication, neglect, or abuse to the administrator of the facility and other officials as required by law.
### Common Pitfalls

- Implementing a compliance program on paper but not in reality
  - Employee training
  - Formulating/adopting policies and procedures
  - Establishing annual auditing and monitoring schedules
  - Constantly examining compliance risk areas
- Lack of effective oversight
- Proactive not reactive

Compliance is a Culture!

### Payment Challenges - SNF

- SNF payments based on RUGs have historically focused on volume
- CMS new model based on patient driven value-based care
- Significantly reduces administrative burden
- PDPM (patient-driven payment model) effective 10/1/19
- Focus is clinically relevant factors using ICD-10 diagnosis codes and patient characteristics to classify patients

### Payment Challenges - SNF

- AHA takes issue with tying payments to patients conditions and needs rather than volume
- PDPM requires less frequent patient assessment with a single assessment at the 5 day mark
- The assessment determines a patient’s classification and per-diem payment for the entire SNF stay
- Potential to create higher-cost IPA adjustments if high cost non-therapy ancillaries are added, thus risk of underpayment
- SNFs have not used ICD-10 codes for payment
Payment Challenges - HHA

- 2019 Proposed Home Health rule renames home health groupings model (HHGM) to patient-driven groupings model (PDGM)
- Bipartisan Budget Act of 2018 required change to unit of payment
  - From 60-day episodes of care
  - To 30-day periods of care
- Eliminates use of therapy thresholds in determining payment
- Implementation expected January 1, 2020
- Proposes to define remote patient monitoring and allow the cost as allowable administrative cost on the cost report

Payment Challenges - Hospice

- OIG report based on 10 years of research
  - Deficiencies in patient care
  - Inappropriate billing
  - Fraud
- Payments have increased from $9.2 million in 2006 to $16.7 million in 2016
- Payment is made based on time spent in care, not services provided

Collaboration

- Acute and post acute care collaboration
  - Aging population
  - Changing reimbursement models
- PAC preferred provider networks
  - Immediate and consistent access to high-quality PAC services
  - Reductions in readmissions and ED visits
  - Increased hospital throughput
  - Reduced average length of stay
  - More efficient discharge process
- Must comply with patient choice
Collaboration

Partnership Challenges

- Different accreditation and staffing requirements
- Different Medicare payment methodologies
- Different Medicare regulations
- Hold PAC accountable for outcomes
- Over-utilization
- Hospitals are increasingly assuming risk – even beyond hospital walls
- Lack of coordination between acute and post acute providers
- Focus on shared goals

QUESTIONS?

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