Arnett Carbis Toothman LLP
CPAs & Advisors

Bridging the Gap: Regulatory Compliance in a Post Acute Setting

The Health Care Compliance Association

October 5, 2018

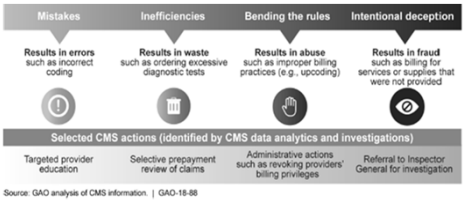
Objectives

- 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



Source: GAO analysis of CMS information. | GAO-18-88

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

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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

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Enforcement

- RehabCare Group, Inc. – Ohio – $399,780
- Signature HealthCARE, LLC – Louisville – $30 million
- George Houser (NF owner) – Atlanta – $6.7 million 20 years
- 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

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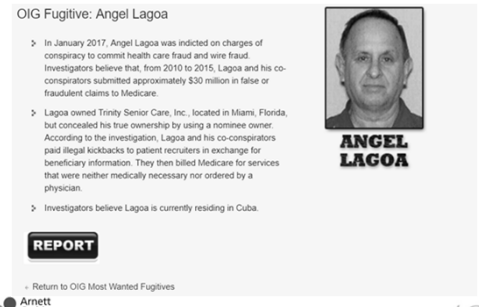
Enforcement

- 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

Enforcement

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

Enforcement



Enforcement

OIG Fugitive: Conrado Dizon Lopez, Jr.

- On December 23, 2014, Conrado Lopez was indicted on charges of health care fraud, conspiracy to commit health care fraud, false claims, false statements related to health care matters, and falsification of records. Lopez is a licensed physical therapist and owner of Total Rehab in Brooklyn, NY.
- Lopez confessed to OI Agents that he was knowingly involved and an active participant in a scheme to defraud Medicare and Medicaid whereby Total Rehab submitted claims to these programs for services that were either not rendered, not medically necessary, not appropriately supervised and/or performed by unlicensed individuals. He also stated that on several occasions he was outside the United States on vacation and when he returned, he signed back dated superbills for the dates of services when he gone, despite knowing this was wrong.
- According to the indictment, between approximately March 2009 and November 2011, providers at Total Rehab submitted and caused to be submitted approximately $9.8 million in claims to Medicare and approximately $8.6 million in claims to Medicaid. During approximately that same period, Lope was identified as the rendering provider on claims submitted to Medicare totaling approximately $1.8 million and on claims submitted to Medicaid totaling approximately $1 million.
- Flight records show that Lopez fled the United States and investigators believe that he is in the Philippines or the United Arab Emirates. He remains a fugitive at-large.

REPORT

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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

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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

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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

Risk Areas

- 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
  - Underutilization
  - 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

Risk Areas

- SNF OIG Compliance Guidance 03/16/2000

• absence of a comprehensive, accurate assessment of each resident's functional capacity and a comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs; [26]

• inappropriate or insufficient treatment and services to address residents' clinical conditions, including pressure ulcers, dehydration, malnutrition, incontinence of the bladder, and mental or psychosocial problems; [27]

• failure to accommodate individual resident needs and preferences; [28]

• failure to properly prescribe, administer and monitor prescription drug usage; [29]

• inadequate staffing levels or insufficiently trained or supervised staff to provide medical, nursing, and related services; [30]

• failure to provide appropriate therapy services; [31]

• 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; and

• failure to report incidents of mistreatment, neglect, or abuse to the administrator of the facility and other officials as required by law.[32]

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

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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

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QUESTIONS?

M. Jill Griffith, CPA, CPC
Senior Manager – Health Care Services
voice: 800.642.3601 x3334
e-mail: jill.griffith@actcpas.com

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