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The HEAT is On: The Government's Fight Against Waste, Fraud and Abuse

March 12, 2010

With increased funding and focus on combating Medicare and Medicaid fraud and abuse, the long term care industry should be aware of risk areas which are the subject of government investigation and which could result in fraud and abuse, or improper claims submission. Through increased transparency, oversight and enforcement activities, the government is stepping up efforts to stem the loss of federal and state health care program dollars to fraud and abuse. Congress, the President, the Department of Justice (DOJ), the Health and Human Services (HHS) Administration and state enforcement authorities continue to raise the stakes by providing increased and expanded enforcement tools, resources and focus by senior leadership to recover Medicare and Medicaid funds lost to fraud.

This past year, the President signed into law the Fraud Enforcement and Recovery Act of 2009 (FERA), which passed both the House and Senate with overwhelming majorities. FERA made significant changes to the federal False Claims Act (FCA) applicable to the health care industry. These changes expanded the scope of FCA liability for health care providers, extended the FCA statute of limitations, provided new whistleblower rights and enhanced the ability of enforcement agencies to pursue health care fraud cases.

A new interagency effort, the Health Care Fraud Prevention and Enforcement Action Team (HEAT), was also created to combat Medicare fraud. HEAT is composed of senior-level officials from the DOJ and HHS who are charged with coordinating the fight against Medicare and Medicaid fraud. HEAT's anti-fraud efforts include: (i) creating "Strike Force" teams in major cities; (ii) assisting state Medicaid offices with provider audits; (iii) strengthening monitoring activities; (iv) analyzing electronic data to find patterns of fraud; (v) training to help providers and law enforcement identify fraud; and (vi) improving citizen access to fraud hotlines.

On January 28, 2010, HHS Secretary Kathleen Sebelius and Attorney General Eric Holder joined private sector leaders, law enforcement personnel and health care experts for a landmark National Summit on Health Care Fraud, the latest initiative of HEAT. The National Summit focused on developing ways to eliminate fraud and abuse in the health care system, including (i) the use of state of art technology to prevent and detect health care fraud and improper payments; (ii) increased support to state Medicaid officials to allow them to conduct targeted activities to fight fraud in their states; (iii) a renewed commitment to expanded data sharing and improved information sharing procedures between HHS and the DOJ; and (iv) increased provider site visits.

In addition, the President's FY 2010 Budget makes fighting health care fraud a top priority. The President called for increased funding for programs with a proven record of preventing fraud, reducing payment errors and returning funds to the Trust Funds. Highlights from the President's budget include a request for $1.7 billion for fraud fighting at the Department of Health and Human Services (DHHS), funding to allow expansion of the HEAT Strike Force Teams, and funding to support better data sharing among investigators, increase oversight and improve data analysis.

The OIG (Office of Inspector General) Work Plan for FY 2010 describes the OIG's planned activities with respect to HHS programs and operations in the next year through audits, evaluations and investigations.

With respect to nursing homes, the Work Plan identifies the following areas for targeted review:

- Medicare Part B payments for psychotherapy services provided to residents during non-covered Medicare Part A SNF (Skilled Nursing Facility) stays;
- Medicare requirements for quality of care in SNFs, to include
  - a review of SNFs' use of standardized Resident Assessment Instrument to develop residents' plans of care,
  - a determination of whether SNFs provided services to beneficiaries in accordance with these plans of care, and
  - a determination of whether SNFs planned for beneficiaries' discharges;
- Accuracy of Resource Utilization Groups coding;
- SNFs emergency plans and emergency preparedness deficiencies cited by state surveyors to determine sufficiency of plans and implementation of plans;
- Criminal background checks for employees;
- Survey and certification reviews of poorly performing nursing homes;
- Medicare Part B services provided to residents whose stays are not paid for under Medicare's Part A SNF benefit; and
- Residents aged 65 or older receiving antipsychotic drugs in absence of conditions approved by the Food and Drug Administration (FDA).

The OIG Work Plan also identifies areas relating to nursing facilities and their residents which have and will be the subject of OIG scrutiny. The Work Plan reports on an OIG investigation of and an agreement by nursing home chain to pay $4 million plus interest to resolve potential FCA liability for violations allegedly committed at 10 of its nursing facilities. The allegations included submitting claims to Medicare and Medicaid for skilled services that were not medically necessary and/or were for patients that did not qualify for the claimed services.

The Work Plan also reports on investigations of substandard care at nursing homes based on alleged failures which put residents at risk for harm which included the failure to maintain adequate staffing levels, properly administer medication, provide adequate hydration and nutrition and prevent accidents. Allegations of a nursing home's failure to monitor and assess a resident or to provide the care and services the resident needs can also result in civil money penalties due to violations of 41 C.F.R. 483.10(b)(11), causing immediate jeopardy to the resident. For example, the Fourth Circuit Federal Court of Appeals recently upheld a determination by HHS that a skilled nursing facility failed to comply with Medicare participation requirements related to its residents' well being and safety (Universal Healthcare/King v. HHS, 4th Cir., No. 09-1093, 1/29/10), and affirmed CMS's (Centers for Medicare & Medicaid Services) imposition of civil money penalties.

With respect to the Medicaid program, the Work Plan lists plans to review Medicaid payments made to continuing day treatment providers, community residences for persons with mental illness, personal care facilities, home health agencies and home and community-based services provided in assisted living facilities. Also, the OIG plans to review Medicaid data to identify nursing facilities that may have provided substandard care resulting in or contributing to beneficiaries' subsequent hospital admissions, including those for diagnoses of pressure sores, infections or both. Finally, the OIG intends to examine how states administer and use civil monetary penalties imposed on nursing homes that failure to meet Medicare and Medicaid health and safety requirements.

With these increased oversight and enforcement activities of the government, it is imperative for long term care providers to operate their facilities in compliance with Medicare and Medicaid laws, rules and regulations. The OIG Compliance Program Guidance for Nursing Facilities identifies specific compliance components and risk areas and offers guidelines for nursing facilities to consider when developing and implementing a new compliance program or evaluating an existing one. As a compliance program can significantly reduce the risk

of unlawful conduct and corresponding sanctions, long term providers should either develop and implement a new compliance program or revisit and update existing compliance programs to assist in their compliance with the laws applicable to their operations.

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