Compliance 101

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Compliance 101

Harmony Healthcare International (HHI)

"HHI **C.A.R.E.S.** about Care"

C.A.R.E.S.™

HHI C.A.R.E.S. About Care

Compliance | Analysis | Audit | Regulatory | Rehabilitation

Reimbursement | Education | Efficiency | Survey

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About Kris

Kris Mastrangelo OTR/L, LNHA, MBA

President and CEO

Owns and operates
Harmony Healthcare International (HHI) a Nationally recognized, premier Healthcare Consulting firm specializing in C.A.R.E.S.
There are no nonfinancial disclosures to share.

"HHI C.A.R.E.S. About Care."

C Compliance ™
A Analysis Audit
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Speaker and Planning Committee Disclosure

- **Disclosures**: The planners and presenters of this educational activity have no relationship with commercial entities or conflicts of interest to disclose. Please visit https://www.harmony-healthcare.com/hhi-team for all speaker's financial and nonfinancial disclosures
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Learning Objectives

1. The learner will be able to state the 7 elements of Compliance
2. The learner will be able to describe 3 reasons to establish a Compliance Program
3. The learner will be able to identify the intent of the False Claims Act

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Historical Perspective of Compliance

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Seven Elements

P-R-E-P-A-R-E

Policies and Procedures

Reporting and Investigating

Education and Training

Prevention and Response

Auditing and Monitoring

Responsibility/Oversight of Compliance Officer/Committee

Enforcement, Discipline and Incentives

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Historical Perspective of Compliance

- Compliance is not new; it reaches back to the 1860's during the Civil War When the False Claim Act (FCA) was passed
- The False Claim Act (FCA) was passed to prevent profiteers from selling bogus goods to the Union army
- The False Claim Act (FCA) has become a powerful weapon against fraudulent claims issued by healthcare providers
- The FCA mandates fines and penalties of double and triple False Claim against a government agency

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Historical Perspective of Compliance

- In 1996 the Health Insurance Portability and Accountability Act (HIPAA) authorized the creation of the Medicare Integrity Program
- This program directed federal agencies (HHS, DOJ, Department of Labor) to develop weapons to combat fraudulent claims and abusive practices of healthcare providers

Office of the Inspector General

- Since the late 1990s, long before the Affordable Care Act legislation mandated that providers put a compliance plan in place, the Office of Inspector General (OIG) started a major initiative to support health care professionals in establishing a compliance program for their offices, organizations and practices

The Affordable Care Act

- The Affordable Care Act (ACA) was passed by Congress and then signed into law by the President on March 23, 2010
- On June 28, 2012, the Supreme Court rendered a final decision to uphold the health care law
- ACA mandates compliance programs for all nursing homes by March 23, 2013

Affordable Care Act

- Section 6401 of the Affordable Care Act provides that a "provider of medical or other items or services or supplier within a particular industry sector or category" shall establish a compliance program as a condition of enrollment in Medicare, Medicaid, or the Children's Health Insurance Program (CHIP)

Affordable Care Act

- The Affordable Care Act further required the Secretary of Health and Human Services (HHS), in consultation with the HHS Office of Inspector General (OIG), to establish "core elements" for provider and supplier compliance programs. In doing so, HHS has the discretion to determine the timeline for implementation of the core elements and the requirement to have a compliance program.

Affordable Care Act Program Mandate

- Intended to induce all health care professionals to implement a compliance program
- Will aid health care providers in better protecting themselves from risk of improper conduct

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Fraud, Waste and Abuse

- The Government Accountability Office has designated **Medicare** as a program at **high risk for fraud, waste, and abuse**
- **Payments** to skilled nursing facilities (SNFs) have been identified as **vulnerable to abuse**
- In 2012 the Office of Inspector General (OIG) found that approximately **25% of SNF Claims** were billed in error

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Wall Street Journal, November 12, 2012

- Thomas Burton, November 2012:
  - "More intensive services were done than actually performed"
  - "Patients could not benefit from it"
  - "Cutting fraud" Obama

OIG Report
Claims in 2009

- 25% billed all claims in error: 1.5 billion
- 26% claims **not supported in the medical record**
- 542 million in overpayment
- “Majority” error “up coded”*
- Many **Ultra High**

* Original RUG was a higher paying RUG than the revised RUG

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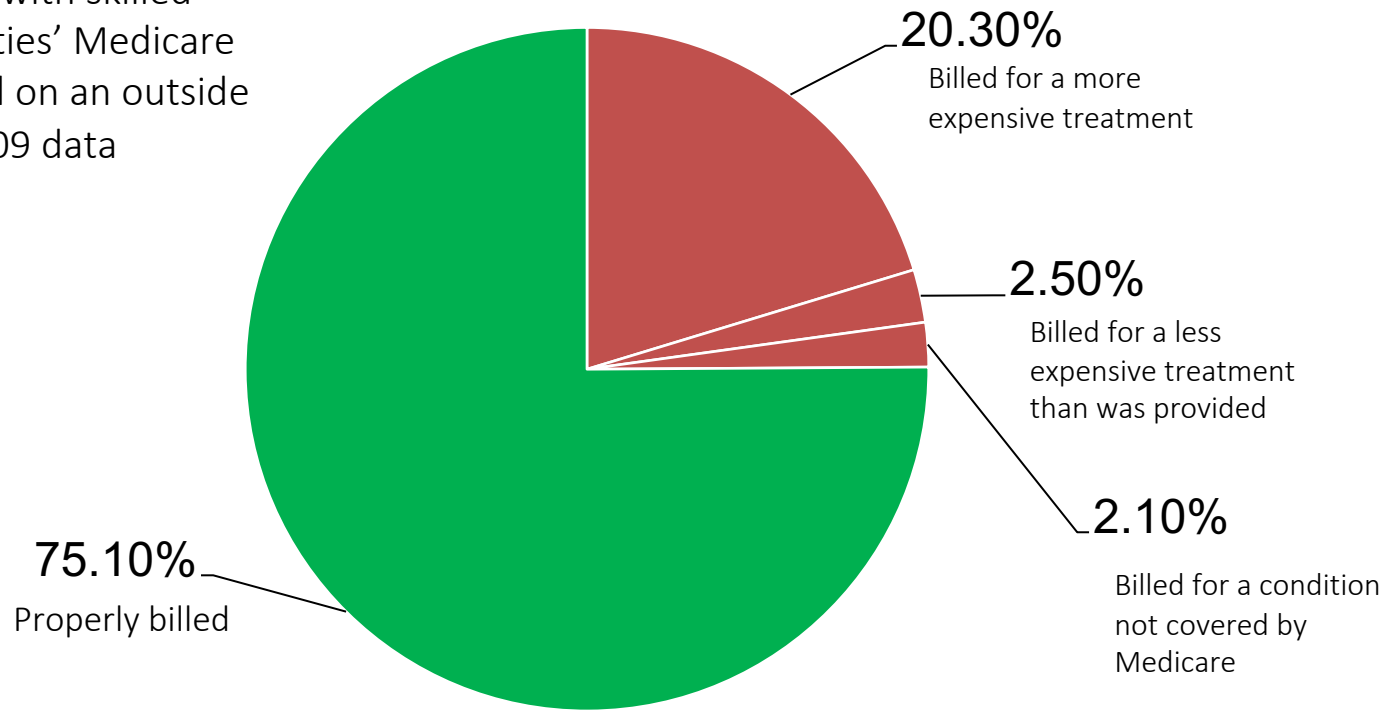
OIG Report
Claims in 2009

Billing Errors

Issues found with skilled-nursing facilities' Medicare claims, based on an outside review of 2009 data



Source: Department of Health and Human Services
Office of Inspector General

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OIG Recommendations

- Increase and expand reviews of SNF claims:
  - CMS should instruct its contractors to conduct more medical reviews of SNF claims
- Use its Fraud Prevention System to identify SNFs that are Billing for Higher Paying RUGs:
  - CMS should use its Fraud Prevention System to identify and target these SNFs
- Monitor Compliance with the New Therapy Assessments:
  - As of October 2011, SNFs must complete a "change of therapy" assessment when the amount of therapy provided no longer reflects the RUG and an "end of therapy" assessment when therapy is discontinued for 3 days
  - CMS should instruct its MACs and RACs to closely monitor SNFs utilization of these assessments through analyses of claims data. Such analyses will identify SNFs that are using the assessments infrequently or not at all.

Compliance Programs

- In 2012, the government received the highest amount of whistleblower complaints in its history
- This, combined with the advent of the Affordable Care Act and PEPPER, leaves the entire SNF industry under overwhelming scrutiny for accurate payment
- Numerous changes taking place specifically within the reimbursement process
- Medicare and Medicaid billing are now the most prominent risk areas in healthcare

Compliance

- The Office of Inspector General encourages SNFs to develop and implement a **compliance program to protect their operations from fraud and abuse**
- Beginning in 2013, **SNFs are required** to have a compliance program

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False Claims Act

- The False Claims Act ("FCA") is violated where any person:
  - Knowingly **presents, or causes to be presented**, to the U.S. government a **false or fraudulent claim** for payment or approval
  - Knowingly **makes, uses or causes to be made or used**, a false record or statement material to get a false or fraudulent claim paid
  - **Conspires** to defraud the government by getting a false or fraudulent claim paid

False Claims Act

- Critical changes have occurred with the False Claims Act
- Most noteworthy change, leaders be advised:
  - Revision of the "intent" to submit an incorrect claim
- Historically, proof of "intent" was required to prosecute
- Today, no proof or specific intent to defraud is required

Fraud and Abuse defined

- If you Would Have, Could Have or Should Have known it is defined as fraud
- The government only needs to show:
  1. The provider had "actual knowledge of the information" or
  2. The person acted in "deliberate ignorance" of the truth or the falsity of the information, or
  3. The person or provider acted in "reckless disregard" of the truth or falsity of the information

Fraud and Abuse Defined

- Abuse is [billing for] "acts inconsistent with sound medical or business practice"
- Abuse can be found where conduct is unintentional but where said conduct directly or indirectly results in an overpayment to the healthcare provider

False Claims Act

- Types of FCA cases include:
  - Therapy or other services that are deemed unreasonable and medically unnecessary
  - Quality of Care ("standard of care claims or worthless claims")
  - Services provided by individuals excluded from the Medicare/Medicaid program
  - Billing errors resulting in overpayments

False Claims Act

- No specific intent to defraud is necessary
- No proof of actual damages, such as payment or approval of the claim needed for liability to attach
- Civil penalty from $5,500 to $11,000 per false claim UPDATE
- Penalties can include three times the amount of damages the government sustained:
  - If report the violation with 30 days of discovery, damages can be significantly reduced
  - If the organization reports first the violation a qui tam is less likely

False Claims Act

- The FCA allows a private person to bring a false claim action on behalf of the government
- This provision encourages employees to become whistleblowers
- The Justice Department revealed that in 2014 nearly $6 billion dollars were recovered under the FCA, over half of that amount was due to cases filed by whistleblowers

The Patient Protection and Affordable Care Act (PPACA)

- In August 2015, the government sued a NY Hospital for violations of the FCA for allegedly failing to refund overpayments for two years after notice of potential billing errors due to a software glitch
- The court agreed with the government that, under the PPACA, an overpayment is identified when a provider has determined, or "should have determined through the exercise of reasonable diligence," that it has been overpaid

What is Compliance?

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What Is Compliance?

- Prevention
- Detection
- Collaboration
- Enforcement
- Efforts to reduce Fraud, Waste and Abuse

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What Is Compliance?

- Compliance is an **ongoing process**
- A **system** of policies and procedures to assure compliance with federal and state laws governing the organization
- A Compliance program must be **effective**
- Part of the organization **structure and culture**
- A commitment to an **ethical** way of conducting business
- A system of doing **the right thing**

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Who Needs Compliance?

- Physician Practices
- Hospitals
- Nursing Facilities
- Home Health Agencies
- Medicare and Choice Organizations
- Ambulance Suppliers
- Third Part Billing
- Pharmaceutical Manufacturers
- Laboratories
- Teaching Institutions
- Research
- DME
- Others

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Why Implement A Compliance Program?

- Paybacks to the fiscal intermediaries may result in audits
- Probation and court –imposed programs
- Government designed programs
- Exclusion from governmental programs
- Reduce threat of whistleblowers (qui Tam) lawsuits

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Why Implement A Compliance Program?

- Demonstrates to the community a strong commitment to honesty and responsibility as a trustworthy provider
- Reinforces employee's innate sense of right and wrong. Providing employees with ways to express concerns to management (hot line, open communication, etc.,) providers strengthen relationships of trust with employees

Why Implement A Compliance Program?

- Helps providers fulfill their legal duty to government and private payors:
  - For example, submitting a claim for reimbursement for an item of service, the provider is affirming the claim is truthful and the services provided are consistent with the program requirements
  - Internal monitoring of claims is an integral part of a compliance program

Why Implement A Compliance Program?

- Compliance programs are cost effective:
  - Requires commitment and resources
  - Can **outweigh the expense** in defending a fraud investigation

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Why Implement A Compliance Program?

- Provides a view of employee and contractors' behavior related to fraud and abuse:
  - Provides ongoing **training and education**
  - **Monitors understanding** and compliance with rules
  - Provides a **process for discipline** for those who violate the rules

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Why Implement A Compliance Program?

- Quality of care is enhanced by a Compliance program through having a code of conduct. A code of conduct establishes the vision. The vision statement and implementation is established through:
  - Training employees
  - Continuous self-assessment
  - Prompt response to deficiencies
  - Enhance the highest quality care

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Why Implement A Compliance Program?

- A comprehensive Compliance program provides established procedures for promptly and efficiently responding to problems that may arise:
  - These processes in place can lead to **early detection** and reporting **reducing risk** and loss of potential false claims

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Why Implement A Compliance Program?

- A effective compliance program can mitigate any sanction imposed by government:
  - A reduction in criminal fines in cases where the organization has an effective Compliance program in preventing and detecting fraud, waste and abuse

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Why Implement A Compliance Program?

- Voluntarily implementing a Compliance program is preferable than waiting for the OIG enforcing through a Corporate Integrity Agreement (CIA)

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Compliance

Seven Elements & QAPI

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Seven Elements

P-R-E-P-A-R-E

Policies and Procedures

Reporting and Investigating

Education and Training

Prevention and Response

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Responsibility/Oversight of Compliance Officer/Committee

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Compliance

- The government only needs to show:
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  2. The person acted in "deliberate ignorance" of the truth or the falsity of the information, or
  3. The person or provider acted in "reckless disregard" of the truth or falsity of the information

Compliance Programs

- Providers have only 120 days to correct MDS errors and submit a billing adjustment for Medicare Part A claims
- Late identification of billing errors yields mandatory self disclosure within 60 days of overpayment identification
- It is a felony not to return the payment
- The civil penalty equates to $5,500 to $11,500 per false claim along with three times the amount of damages which the government sustained

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Compliance Programs

The only defense for an incorrect claim is a **great offense** in the form of an effective

Compliance Program

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QAPI

What is QAPI?

- "QAPI is about **critical thinking**. It involves figuring out what is **causing** certain problems and implementing **interventions** and solutions that address the root causes of the problems, rather than just the symptoms."

Karen Schoeneman, Past Technical Director, CMS Division of Nursing Homes

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Closing Thoughts

- State the intent of the False Claims Act
- Know the top 3 reasons to establish a Compliance Program
- Institute all 7 elements of Compliance

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Our Process

- Prescribed medical record review process that encompasses HHI's core business
- HHI Specialists provide expertise through teaching and training and an extensive chart audit process in order to ensure:
  - MDS Accuracy
  - MDS Supporting Documentation
  - Billing Accuracy
  - Nursing Documentation
  - Therapy Documentation
  - Clinically Appropriate Care

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HHI
Services and Plans

Gold C.A.R.E.S.
2 Year Service Plan

Platinum C.A.R.E.S.
3 Year Service Plan

List of HHI Services

PDPM Training and Audits | Medicare | Compliance | Rehab Program Development | Seminars | MMQ Audits | Mock RAC Audits | Rehab Certification | Mock Health Inspection Survey | MDS Competency | Talent Management | Denials Management | Compliance Certification | Clinically Appropriate Stay | QAPI | QIS | Medicare Part B Program | MDSC Mentor Program | Case Mix Consulting | Professional Development | Leadership Trainings | Regulatory and Survey Assistance | Five Star | PBJ | Quality Measures | Analysis | Staff Training | Infection Control and More!

Silver C.A.R.E.S.
1 Year Service Plan

A La C.A.R.E.S.
Customized Service Plan

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Our Senior HHI Specialists

- Founded in 2001
- Privately owned and operated
- Ranked among Inc. Magazine's top 5,000 fastest growing private companies in America three years in a row
- Active monthly contracts in 24 states
- Over 1,000 Skilled Nursing Facilities serviced
- Over 3,000 Clinicians Certified on the MDS

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https://www.harmony-healthcare.com/harmonyhelp

Live Support Available
8:00 a.m. – 5:00 p.m. EST

HarmonyHelp

With **HarmonyHelp**, Harmony Healthcare International (HHI) provides an invaluable resource for the entire interdisciplinary team. Imagine having questions answered by a HHI Specialist within minutes of the inquiry. Fill out the form on the right to learn more about HarmonyHelp and our various Service Plans.

The **Knowledge Center** is loaded with **information** that will assist with your daily responsibilities at your facility. This self-help site is broken up into **5 Sections:**

Manuals I Tools I C.A.R.E.S. Community I Hot Topics I FAQ (Frequently Asked Questions)

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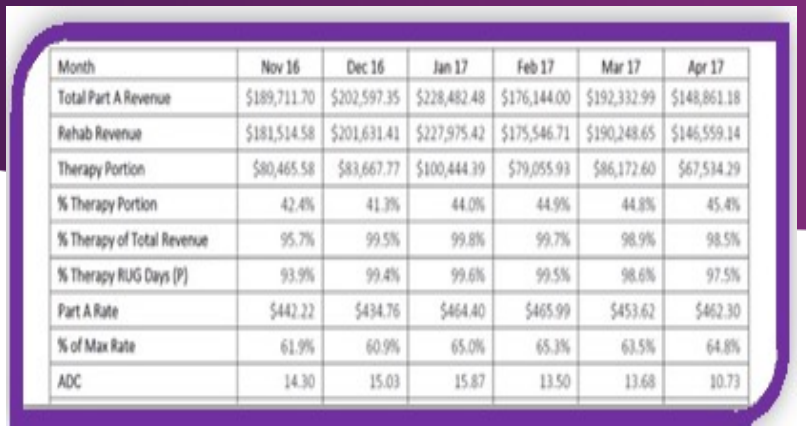
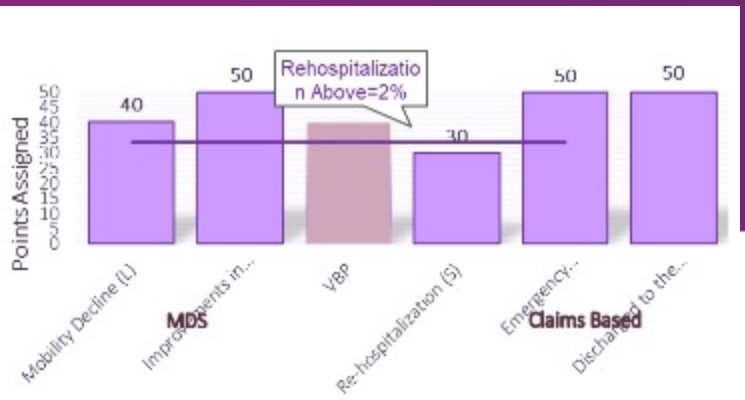
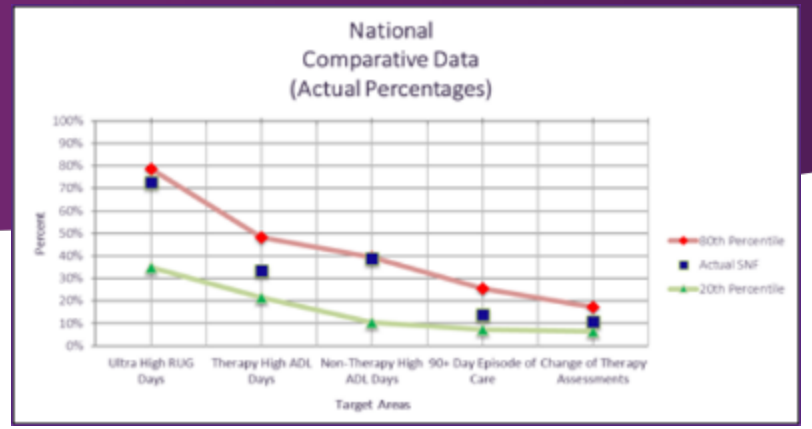


Month	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17
Total Part A Revenue	$189,711.70	$202,597.35	$228,482.48	$176,144.00	$192,332.99	$148,861.18
Rehab Revenue	$181,514.58	$201,631.41	$227,975.42	$175,546.71	$190,248.65	$146,559.14
Therapy Portion	$80,465.58	$83,667.77	$100,444.39	$79,055.93	$86,172.60	$67,534.29
% Therapy Portion	42.4%	41.3%	44.0%	44.9%	44.8%	45.4%
% Therapy of Total Revenue	95.7%	99.5%	99.8%	99.7%	98.9%	98.5%
% Therapy RUG Days (P)	93.9%	99.4%	99.6%	99.5%	98.6%	97.5%
Part A Rate	$442.22	$434.76	$464.40	$465.99	$453.62	$462.30
% of Max Rate	61.9%	60.9%	65.0%	65.3%	63.5%	64.8%
ADC	14.30	15.03	15.87	13.50	13.68	10.73





Complimentary HHI Offerings

- PDPM Revenue and Risk Analysis
- Medicare Part A Revenue and Risk Analysis
- Five-Star Quality Measure Points Analysis
- PEPPER Analysis

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