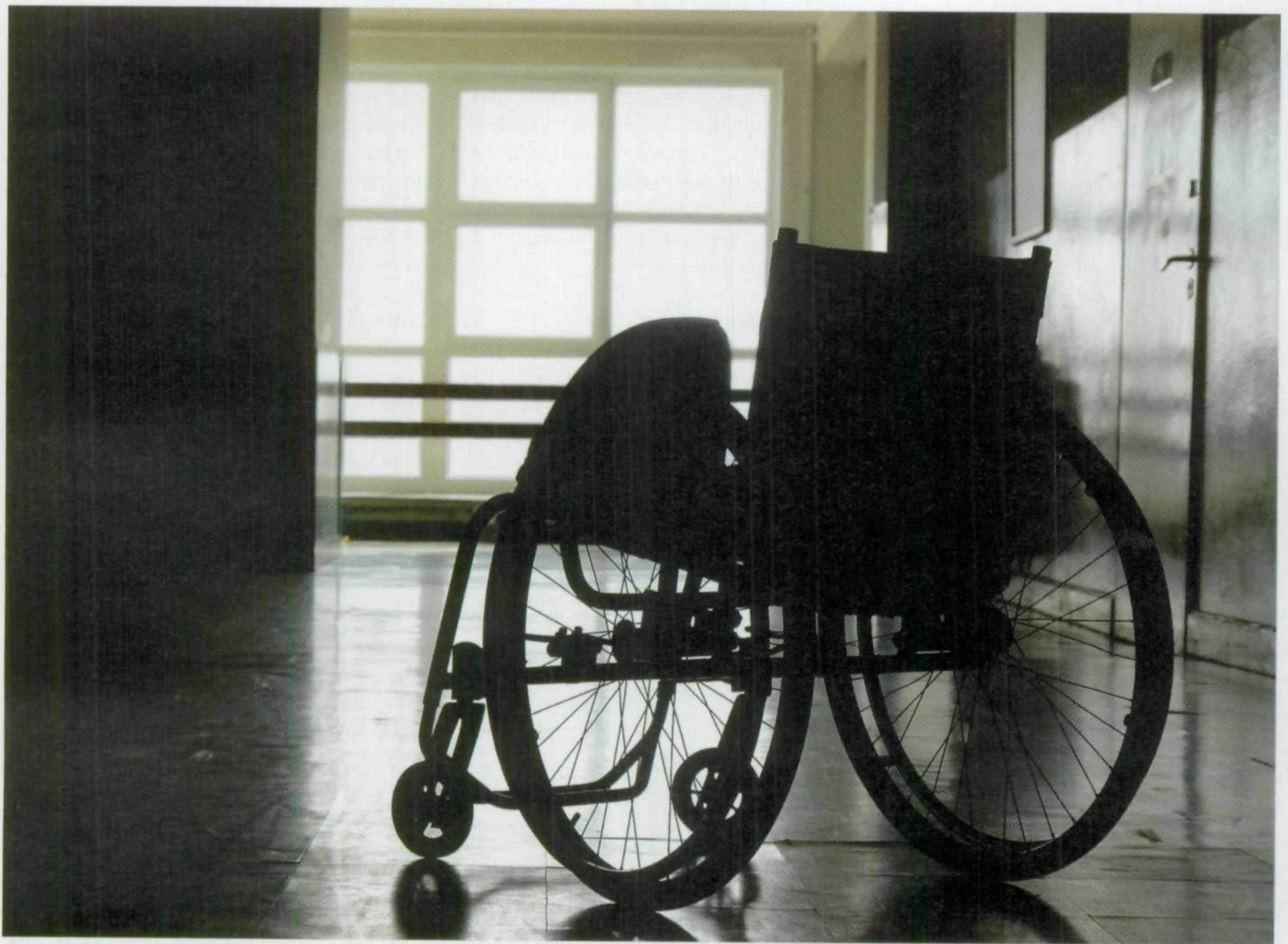

Controlling Nursing Home Fraud

By Gerald H. Lander, Alan Reinstein, and Jeannine A. Busch

CPAs auditing nursing homes and hospices should be aware of the potential for fraud in the industry. Nursing home fraud adversely affects those paying for such care, both as caregivers and as taxpayers through support of Medicare and Medicaid, which constitute a large percentage of the country's gross domestic product. According to the Center for Medicare and Medicaid Services, healthcare spending constituted 16% of U.S. GDP in 2006 and is expected to grow to 19.6% of GDP by 2016, reaching over $4.1 trillion.

In a 2006 paper ("Whistle Blowers: False Claims Act"), Janie Gardner estimates that almost 10% percent of the U.S. annual budget is paid to companies or persons who are defrauding the government, of which a large part is due to Medicare and Medicaid fraud. A 2004 Office of the Inspector General of the State of Florida audit, for example, found not just individual misdeeds but "that the State permitted improper Medicaid payments for new admissions totaling $176,853 ($99,957 Federal share) to sanctioned nursing homes." Recognized as seriously acute over a decade ago, the fraud problem has occasioned recommendations as severe as doing away with nursing home care entirely to avoid the misspending of $50 billion in government funds (Peter Uhlenberg, "Replacing the Nursing Home," *Public Interest*, Summer 1997).

This article surveys the current state of nursing home fraud and suggests ways that CPAs can help control this abuse.

Medicare and Medicaid

Medicare provides health insurance to people aged 65 or older, those entitled to Social Security disability payments for more than two years, and those with end-stage renal disease, regardless of income. Medicaid covers nursing home care and pays for skilled, intermediate, and long-term care for low-income individuals. States have their own Medicaid plans, receiving prospective, flat-rate, and cost-based payments, some of which involve ceilings, case-mix adjustments, and efficiency incentives. According to the U.S. Office of the Inspector General, Medicare served 43 million beneficiaries at a cost of $337 billion in fiscal year 2006, while Medicaid served 47 million people, costing the states $137 billion and the federal government $180 billion.

Nursing homes requesting Medicaid reimbursement must detail their revenues and expenses in cost reports that are subject to state audit. For example, in Michigan, they must complete Medical Services Administration Medicaid Program Form 1579, which contains around 1,000 different lines. State auditors usually focus on 100 to 150 major expense categories. Nursing homes receive the highest reimbursements for base costs (e.g., nursing supplies, nursing wages, and food), the next highest for support costs (e.g., maintenance supplies and administrative salaries), and lowest for plant costs (e.g., reimbursable leasing costs and property taxes). Some states, however, reimburse interest expenses based upon formulas that consider the nursing home's average borrowings.

Reimbursement of certain capital costs are based on the annual depreciation reported. Nursing homes should capitalize large expenses (e.g., exceeding $5,000), which usually affect major repairs, maintenance, or equipment. Moreover, unlike plant costs (which have no preset limits), base/support costs often have a built-in profit factor (up to preset limits). Incorrect reporting of capital costs could result in a nursing home being improperly reimbursed on an accelerated basis. Auditors should test capital expenditures to assure compliance.

State auditors look for correct expense classification categories and for unallowable expenses, such as late fees, penalties, and certain types of pharmacy and dentistry, and compare filings on their tax returns and accrued general ledger amounts. They usually base further investigations on amounts of expense claimed and comparisons to the prior years. They also compare vendor invoices to amounts claimed, perform their own bank reconciliations, and compute interest.

Medicare and Medicaid revenues arise primarily from census data of patients receiving approved medical services (at current rates). Thus, financial fraud often entails nurses or other caregivers falsely certifying that the patient was actually in the nursing home or received unapproved treatment, and the administrative staff falsely attesting to the appropriateness of the charges billed and reconciling such charges to the financial statements. Coding documentation drives both revenues and expenses, and state and federal auditors, plus outside CPAs, review these scores, often focusing on consistency, including testing to see if the facility has adequate nurses on staff to handle the documented treatments. CPAs who perform nursing home audits should consider using the services of a specialist (such as clinical staff) for reimbursement issues.

Medicare payments evolved from patient cost reimbursements to predetermined fee schedules. The Balanced Budget Act of 1997 required that most of the services then paid on a cost reimbursement methodology eventually convert to a fee schedule. While Medicare payments are generally based partly on providers' costs and partly on the prospectively established fees, the rules differ for nursing homes. Nursing homes still prepare Medicare cost reports, but receive Medicare A reimbursement based on clinical acuity compared to a 53-category list (resource utilization group, or RUG score)—rather than their incurred costs for taking care of specific patients. Moreover, Medicaid reimbursements are generally cost-reimbursed. Medicare auditors should thus examine of the facilities' procedures to identify reimbursable costs and report them appropriately on filed cost reports.

Internal Controls and Examples of Fraud

Since most owners usually own only a few nursing homes and many are not-for-profit organizations with financial constraints and a small administrative staff, many homes have internal controls that are weak or nonexistent. Thus, CPAs often cannot rely on such internal controls in performing their audits, despite authoritative audit standards that require this assessment. Independent auditors generally perform increased testing of a nursing home's detailed records, as well as summarizing and disclosing such internal control weaknesses in their management letters.

Much Medicaid fraud involves administrators paying personal expenses, such as billing Medicaid for furnishing a vacation home's chairs and tables. Another example of fraud is not reporting revenues to the IRS for patients who stay for only a few days but request Medicaid reimbursement. Nursing homes also can write (but not mail) checks; fraud can occur when, after the auditors match the checks to invoices, the nursing home voids the check, returns the supplies, and bills Medicaid for the expenses. Other examples of fraud include billing fictitious patients, administrators overcharging services and splitting the proceeds with the vendors, "accidental mistakes" made on cost reports, and billing Medicaid for working hours spent on a side business. "Gang visits" are a type of fraud that occurs in nursing homes when doctors or other healthcare practitioners bill for services for all or nearly all residents, when the physician really did not provide services to all residents and would have been logistically incapable of doing so.

Despite the fact that violators face fraud penalties of 100% from Medicaid as well as criminal penalties, fraud persists. More than 30,000 Medicare providers in seven states failed to report over $1 billion in federal taxes in 2006 (Richard Wolf, "Probe Uncovers 30,000 Medicaid Providers Cheating IRS," *USA Today*, November 14, 2007). Writing in *Fraud Magazine*, Richard Carozza stressed that, if conservative industry estimates of 3% to 5% losses from outright fraud are accurate, annual losses could range about $51 billion to $85 billion—but that some government estimates put fraud loss at over 10% ("Health-Care Fraud Drains Lifeblood from Patients, System," March/April 2006).

Supplies

Fraudsters often focus on false reimbursements for nursing home supplies, because they come from outside parties subject to limited government oversight. They employ techniques such as billing for unneeded supplies, double billing, upcoding, "lick and stick" relabeling schemes, billing for phantom supplies, billing for brand-name supplies, billing for unlicensed or unapproved drugs, and misrepresenting the value of imported goods—all of which are detailed below.

Fraudster suppliers bill Medicare directly for prepackaged supply kits rather than through the nursing home for a specific patient, allowing them to ship, bill, and collect for unnecessary kits. Some sell nursing homes whole supply kits rather than the specific items in the kits that the patient requires.

Suppliers and nursing homes can upcode bills for more expensive (e.g., brand-name) items rather than the less expensive items that were actually delivered (e.g., generic equivalents). A "lick and stick" fraud entails lying about prescription drugs' true wholesale price.

Double billing arises when fraudsters charge the government twice for the same goods or services, as in the notable case in which New York State agreed to pay up to $11 million to settle a class-action lawsuit alleging that thousands of poor, disabled, and elderly nursing home residents were cheated out of millions of dollars in the late 1980s ("New York Settles Lawsuit in Nursing Home Fraud Case," *Buffalo News*, November 17, 2006). The lawsuit claimed that the state mishandled Medicaid and Medicare funds and wrongfully collected insurance co-payments from more than 13,000 nursing home patients. Allegedly, the state knowingly authorized nursing homes to double-bill insurance companies for the same services, such as billing medical expenses to Medicaid that were already covered by Medicare, and received kickbacks from the nursing homes for allowing them to double-bill.

Some fraud victims are unknowingly billed for unlicensed or unapproved drugs or are kept unaware of known product defects in order for the nursing homes to be able to continue to sell or bill the government for the products (The False Claims Act Legal Center, "What Is the False Claim Act and Why Is It Important?" 2006). Fraudsters will also misrepresent the value of imported goods or their country of origin for tariff purposes, or undervalue goods from other countries in order to minimize the import tax.

Hospices

Hospices and mental health services can also commit or be party to fraud, for example, when doctors provide unneeded medical services or bill unperformed services to nursing homes, hospices, and mental health centers. A U.S. Department of Health and Human Services review of mental health services provided to nursing home residents found that Medicare paid unnecessary expenses for 32% of such services (G. F. Grob, April 16, 1997, testimony on fraud, waste, and abuse in nursing homes). For example, a Pittsburgh nursing home administrator was found guilty of altering records to cover up inadequate patient care, defrauding Medicare and Medicaid out of over $7 million from 1999 to 2003 ("Former Nursing Home Administrator Convicted of Fraud," *Philly Burbs*, August 24, 2005).

Improper interrelationships between hospice services and nursing homes can encourage illegal practices. The U.S. Department of Health and Human Services found that up to "one in five hospice patients who live in nursing homes may be erroneously enrolled." Fraud investigators have found that hospices provide many services to nursing home patients that are available to them at the nursing home, thus imposing extra Medicare and Medicaid charges.

The hospice situation is especially complex for terminally ill nursing home patients, who often receive both Medicare and Medicaid reimbursements. Focusing on pain control, symptom management, and patient and family counseling, Medicaid programs pay 95% of the daily nursing home rate to the hospice, and Medicare pays the hospice the same daily rate it pays for at-home patients ("Nursing Facility Fraud and Abuse," Arkansas Senior Medicare/Medicaid Patrol Training Materials, 2006). This complicated financial situation provides incentives for fraud. In order to elect the hospice benefit, a Medicare beneficiary must be entitled to Medicare Part A services and be certified as terminally ill, that is, have a medical prognosis of a less-than-six-months' life expectancy, if the illness "runs its normal course" ("Fraud and Abuse in Nursing Home Arrangements with Hospices," Office of Inspector General, Special Fraud Alert, March 1998). Medicare will then continue to pay for nonhospice care from the patient's physician and for nonterminal related illness treatment.

Fraud can arise when a hospice works directly with a nursing home. Hospices receive identical per diem rates whether they function at the patient's home or in the nursing home, regardless of the amount of service provided. A Medicare hospice patient in a nursing home who is also eligible for Medicaid would thus receive at least 95% of the daily home nursing rate, but the hospice is then responsible for paying the nursing home for the patient's room and board.

Nursing homes employing hospices receive more money for providing fewer services to more patients. That is, the hospice receives a flat fee per patient for each day the patient is enrolled in its hospice program, regardless of the number of services or medications provided. The financial payment system rewards hospices for increasing their number of patients, which can lead to decreased quality of patient care. Hospice caregivers working in a nursing home can visit more patients than those taking care of patients at their own homes, creating incentives for hospice care in nursing homes. The hospice provider can thus see more patients and make more money while the nursing home gains funds by keeping those patients at its facilities, having Medicaid pay for almost all of that patient's room and board, sometimes even receiving kickbacks from the hospices.

Kickbacks

It is possible for nursing homes to evade accusations of fraud while colluding with a hospice. Nursing homes often state that they want to work with only one or two hospices because they want to monitor the hospice's qualifications and safety record. Nursing home operators can then coordinate care and maintain control of the premises. But some nursing home operators or hospices may wrongfully offer kickbacks to influence the selection of a hospice.

The antikickback statute, section 1128B(b) of the Social Security Act, prohibits knowingly and willfully soliciting, receiving, offering, or paying anything of value to induce

referrals of items or services from a federal healthcare program. Nursing home hospices sometimes receive kickbacks in the form of a patient's room and board, as when they get a patient's Medicaid payments that should then be paid to the nursing home to cover those charges. Kickbacks occur when the hospice overpays the nursing home for the patient's room and board bill, which, in turn, provides an incentive to the nursing home to assign more of their patients to that particular hospice in order to receive extra money (S. Wicke, "Nursing Home Facilities Must Make Clear Distinction Between Discounts and Kickbacks," *Journal of Health Care Compliance*, May/June 2003).

Other kickbacks involve offering discounted or free services to nursing home patients to induce the nursing home to refer its residents to that hospice. Hospices can pay nursing homes for additional Medicare-covered services in their room-and-board costs, providing the nursing home extra funds for no additional services. Hospices sometimes refer their patients to the nursing home in hopes that it will refer their residents to the hospice, a practice that violates the antikickback statute.

Mental Health Services

Fraud often occurs in nursing home–provided mental health services. U.S. law requires nursing home residents to have a mental health evaluation, but does not require testing for physical illnesses, nutritional deficiencies, or other causes of distress. An Inspector General study testing the adequacy of mental health services provided by nursing homes concluded that "32 percent of the services paid for by Medicare were unnecessary, i.e., $17 million or 24 percent of all 1993 Medicare payments" (Grob 1997).

Regulatory Measures

CPAs should be knowledgeable of the many federal and state regulations governing Medicare and Medicaid reimbursement involving nursing homes. For example, combining federal regulations with the Ohio Administrative Code reveals that reimbursable costs are necessary and proper to deliver patient care. Facilities treating patients both in a certified hospital and in a noncertified facility attached to the hospital (e.g., for their physicians' outpatients) receive no reimbursable costs related to the physicians' patients. Nonallowable costs should be treated as either 1) reduction in the provider's total costs for the direct costs of nonallowable activities; or 2) step-down allocation for those nonallowable activities that would typically be expected to absorb allocated overhead or other costs, such as hospital space leased to others.

Medicare considers the following to be nonallowable costs: patient telephones, televisions, and radios; drug and medical supplies sold to nonpatients; physician recruitment; community service-offered patient education or general health awareness programs; country club memberships; interest expense on Medicare overpayments, fines and, penalties; fines and penalties resulting from violations of federal, state, or local laws; entertainment, including tickets to sporting and other entertainment events; bad debt expense, except specific bad debt expense related to Medicare beneficiaries; depreciation on nonpatient care assets; and goodwill expense.

CPAs and government auditors should also use helpful analytical tools to compare client data for current and prior years and look for items such as changes in lengths of stay, gross/net revenue per inpatient day or discharge, proportion of inpatient and outpatient revenue, gross/net revenue and visits per physician, gross/net revenue per nursing home resident, price per unit (equipment, supplies) or gross margins, and fees paid to third-party billing companies. Besides traditional audits, many nursing homes engage CPAs to use agreed-upon procedures to test compliance with appropriate guidelines.

Focus on Areas of Risk

The Office of the Inspector General, Carozza, and others have called the following items the major risk areas for Medicare/Medicaid fraud:

- Billings for excessive or duplicate dosages of prescription drugs for Medicare;
- Disenrollment of deceased beneficiaries;
- Unallowable payments to terminated Medicare providers/suppliers;
- Medicaid payments for ineligible managed-care members;
- Appropriateness of payments for physical and occupational therapy services;
- Medicare/Medicaid credit balances;
- Upcoding—charging for a more expensive service, such as a visit to a specialist when the patient actually saw a nurse or an intern;
- Doctor shopping—bouncing from one doctor to another to obtain multiple prescriptions for controlled substances;
- Unbundling—breaking down a multistep procedure or service into a series of separate or distinct services to increase the total amount of reimbursement;
- Other duplicate billings or improperly using time-based codes; and
- Providing unnecessary care, such as tests, surgeries, and other procedures.

Examples of Testing a Nursing Home's Internal Controls

Similar to other audits, nursing home engagements require CPAs to associate audit procedures with the assessment of internal controls. Such a procedure could include the following steps:

Ensure that revenue and receivables are correctly recorded in amount, account, and period based on contractual arrangements with respective payer sources. An internal control feature might compare periodically recorded amounts of revenue and receivables to the original contract, or embedding the contract terms in client software that calculates all billing information based on services rendered. Computer application controls should preclude the manipulation of accounting data and be testable by the IT auditor. Before auditors can rely on application controls, identify, review, and test the reliance of general controls over the IT environment.

Management should review monthly days sales outstanding (DSO) and variances in excess of certain number of days.

Record allowances for doubtful accounts using established criteria and assumptions for the monthly review of management, including a review of the adequacy of prior-period allowances.

Check correct recoding of amounts, classifications, and periods of payroll costs (e.g., the payroll supervisor compares payroll per employee to individual time cards the employees file and sees if the correct hourly rate helps compute payroll). Computer application controls usually preserve the accuracy and reliability of information used to calculate payroll. IT auditors could audit the presence and effectiveness of any controls, but would want to test the existence, nature, and reliabili-

ty of the general controls over the IT environment.

When potential large risks exist, compare log reports that therapists submit periodically to Medicare billings to ensure proper documentary support for Medicare billings (e.g., the doctor's recommended therapy compared to the therapy actually provided). To strengthen internal controls, some facilities review or ask a third party to review resident files to confirm that the documentation, therapy, and other factors support the RUG scores.

To test for overfilling (e.g., a therapist reporting the administering of more therapy than could be achieved in a hospital in an eight-hour shift), review the number of patients treated during the time period the therapist was present at the healthcare facility to determine the reasonableness and likelihood that the therapy claimed to have been provided could have been provided. Interviewing patients can help to determine the therapy frequency, nature, and success, within limits; many nursing home residents suffer from dementia or other similar diseases, or do not know what services their RUG scores dictate.

Review cost reports submitted to Medicare at year-end to determine that they are accurate and reliable, and that private payee costs were not inappropriately placed on Medicare cost reports. A CPA could analyze the sum of provided monthly therapy minutes in a specific cost category with the number of patients receiving such treatments and the number of available staff to handle such treatments. For instance, a facility holding 10 patients who can receive up to 40 minutes per day of massages should have at most 12,000 minutes (200 hours) per month of reimbursable costs. Obviously, reimbursement requests for 400 hours per month would require further explanation—especially if the facility employs only one physical therapist.

CPAs should note that comparisons to Medicare RUG scores usually help to justify whether the nursing homes provided adequate therapy to justify the selected RUG category rather than whether the costs are allowable.

Other Methods to Detect Nursing Home Fraud

Carozza notes that many insurers use system edits and other "add-on" computer logic to ensure that claims are paid correctly and to detect many fraudulent claims, focusing on anomalies and patterns of billing that fall outside expected norms. They also work together to share information and emerging technologies to control fraud.

In February 2006, President Bush signed into law the Deficit Reduction Act of 2005, which provided 10% point increases in the shares of Medicaid recoveries to states that establish false claims acts. The law also added "whistleblower" incentives and protections to those reporting Medicaid fraud. For example, Ciena Healthcare Management, Inc., of Southfield, Mich., will pay about $1.25 million to settle a civil lawsuit alleging it improperly billed Medicaid and Medicare for inadequate care at four of its 30 managed nursing homes (Paul Egan, "Nursing Home Company Settles Suit Alleging Improper Care," *Detroit News*, August 20, 2007).

The former acting director of one of Ciena's facilities will also receive about $174,000 from this settlement plus legal fees for bringing a whistleblower lawsuit that uncovered the problem. Federal law grants private citizens who report fraud in federal programs 15% to 25% of the amount the government recovers.

Auditors' Role in Minimizing Medicare Fraud

Many of the newer auditing standards address the steps that auditors must take regarding the heightened sensitivity to fraud. Professionals should design and perform their procedures accordingly. For example, Statement on Auditing Standards (SAS) 99 and the recent risk assessment audit standards, such as SASs 109 and 110, contain many useful suggestions for minimizing potential nursing home and other types of fraud, including an assessment of the facilities' integrity and the "tone at the top."

Some specific risk areas include:

- the facility over-using incentive-based compensation;
- financial relationships with potential referral sources;
- unusual staff turnover;
- duplicate services covered by outside grants; and
- due diligence on prior issues, acquisitions, and joint ventures (Deloitte, "Medicare and Medicaid Billing Compliance: Managing Your Risk," webcast, October 17, 2007).

Auditing for Medicare fraud generally parallels other types of audits. For example, practitioners can analytically ascertain the reasonableness of the number of Medicare patients that a physical therapist can treat in one day, and ascertain if the hospital misallocates too many general operating costs to Medicare. To take advantage of Medicare reimbursement policies, fraudsters can allocate many common Medicare/non-Medicare costs to Medicare-reimbursable categories. For example, a nursing home could allocate as much of a diagnostic machine as possible as reimbursable Medicare costs. Similarly, it could even allocate such common costs as office furniture and other general and administrative costs to Medicare, thereby defrauding taxpayers into subsidizing the entity's operations. In addition, fraudsters often manipulate reimbursable costs, for example, attesting that one physical therapist sees 25 Medicare patients per day, when physical therapist assistants or other untrained persons actually treat these patients (or, worse, no one actually helps them). As a further test, CPAs could request correspondence from the state auditor related to a nursing home's audits and review the adjustments that these auditors requested.

Iowa State Auditor David A. Vaudt and his staff have developed some excellent procedures that practitioners can adopt in auditing hospitals, including Medicare reimbursements (www.auditor.iowa.gov/practice_aids/PrgHospital08.pdf). This audit program includes such areas as audit planning, review of internal control, analytical procedures, and audit and accounting problems. Some specific audit procedures dealing with Medicare include reviewing the validity and assumptions of third-party reimbursement reports (including the effect of Medicare Peer Review Organization program), payment denials, and their effect on the current year's financial statements.

Practitioners can also apply the provisions of the AICPA's Statement of Position (SOP) 99-1 to help hospitals and other healthcare entities evaluate their compliance with corporate integrity agreements with the U.S. Department of Health and Human Services Office of the Inspector General; SOP 99-1 could also be useful in evaluating a voluntary compliance program. SOP 99-1 discusses

how to conduct and report on the findings of an agreed-upon procedures engagement in accordance with the AICPA Statements on Standards for Attestation Engagements, in light of particular client agreements. For example, CPAs should use SOP 99-1 to design procedures that will ascertain whether the hospital properly allocates common costs to their Medicare and non- Medicare components. They should also recognize SAS 109's warning that detected misstatements are often not isolated occurrences, and SAS 110's requirements to respond appropriately to significant matters.

In 1995, the Clinton administration launched Operation Restore Trust to address healthcare fraud. This antifraud and antiabuse initiative began in five states, and soon recovered nearly $190 million from fraudulent healthcare schemes (Michael Siegel, "Compliance Restores Trust," *Nursing Homes*, April 1, 1998). Nursing homes had to enforce a compliance program that was "reasonably designed, implemented and enforced so that it generally will be effective in preventing and detecting criminal conduct." Effective plans under Operation Restore Trust included: compliance standards and procedures, oversight responsibilities, delegation of authority, employee training, monitoring and auditing, enforcement and discipline, and response and prevention.

A Public Trust

Differences do exist between CPA auditors looking for, identifying, and detecting potential financial statement fraud and doing the same with regard to Medicare and Medicaid. The CPA's major task in the latter case is not to detect fraud, but, given the prominence of these government programs and the incidence of fraud in their administration, the public will expect special diligence from CPAs auditing Medicare- and Medicaid-related documents. America's aging population will surely place additional pressure on nursing homes and ancillary facilities to control their costs properly and lawfully. CPAs can play a key role in helping nursing home and hospice clients to manage the health of older Americans as well as in improving the public trust in such institutions and their funding. ❑

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