Skilled Nursing Facilities Targeted in Government Enforcement Actions and *Qui Tam* Lawsuits

Skilled nursing facilities (SNFs) have been the subject of multiple high-profile False Claims Act settlements in recent years, and new pronouncements and pending enforcement actions suggest that SNFs will continue to face government scrutiny going forward. Given the current climate, companies providing skilled nursing care should be proactive in developing, reviewing and updating their compliance programs and internal controls. This may mitigate the risk of drawing unwelcome government attention. For those SNFs that nevertheless find themselves in the crosshairs — whether because they receive a subpoena, are the subject of a *qui tam* complaint, or even face more routine questions as part of a regulatory audit — having quality processes and procedures in place can position the SNF to better defend the action.
SNFs provide short-term rehabilitation and nursing care for patients recently discharged from acute care settings. Unlike long-term care facilities, such as nursing homes, SNF stays for qualified beneficiaries are often covered by Medicare. The market for SNF services has grown significantly in recent years, and SNF stays now account for about 8 percent of Medicare’s total fee-for-service expenditures on an annual basis. In fact, every year, nearly two million Medicare beneficiaries (almost 5 percent of all Medicare beneficiaries) use SNF services at least once.

Given how significant Medicare spending on SNF services is, it is no surprise that SNFs have become a significant target of regulatory audits and, more significantly, False Claims Act litigation. Since 2016, the Department of Justice has settled several multimillion-dollar False Claims Act cases with SNFs, including at least six worth more than $10 million and two separate settlements worth more than $120 million each. In line with the Yates memorandum on the liability of individual corporate officers, some recent settlements have also included financial penalties against individual SNF officers and board members. Despite these enforcement successes, OIG has indicated that its own data analytics continue to show that “SNFs have increasingly billed [Medicare] for the highest level of therapy even though key beneficiary characteristics remain largely the same,” suggesting that billing practices continue to inflate claims and ensuring that SNFs will remain under the microscope.

Though some False Claims Act claims against SNFs involve allegations of services that were never actually rendered, most major False Claims Act cases are more nuanced, involving allegations that services provided or billed did not meet the Medicare program standard of being “reasonable, necessary, and skilled.” In the SNF context, “reasonable, necessary, and skilled” means that the services provided to the beneficiary were medically necessary, supported by the documented assessment of health care professionals, and provided by professionals of appropriate skill and licensure. A service that does not meet these requirements is not eligible for Medicare reimbursement and can form the basis of a False Claims Act claim.

SNFs are particularly vulnerable to claims that they have overbilled for unnecessary care. Unlike many other medical services covered by Medicare, SNFs are most often compensated by Medicare on a per diem basis through Medicare’s Prospective Payment System (PPS), where the amount of the per diem reimbursement depends on the level of care provided to the patient. This system presents particular opportunities to draw allegations of abuse, and most successful False Claims Act cases have involved some
allegations of abuse related to the PPS per diem compensation system — either that the SNF engaged in a pattern and practice of billing for more intensive (and thus expensive) care than necessary or billed for longer stays (and thus more days) than necessary.

With their services and billing practices under the microscope, it is extremely important that SNFs take measures to ensure compliance and mitigate their risk of an enforcement action, including the following:

**Develop a Robust Compliance Program and Create a Culture of Compliance**

Several of the major FCA settlements with SNFs have involved allegations that corporate management pressured facility staff to inflate Medicare billing through inappropriate company policies, statements and culture. For example, DOJ has now asserted in multiple matters that incentive policies that provide financial compensation for employees tied to meeting Medicare billing targets (or that penalize employees who fail to meet such targets) may be considered corporate encouragement of fraudulent billing practices.

As part of their regular compliance programs, SNFs should collect and review company policies, statements and internal documents to ensure that billing guidelines and practices are clearly explained and that the importance of complying with Medicare program guidelines is emphasized throughout.

Having appropriate policies on paper is not enough. Management must reinforce the policies through their actions, fostering a culture of compliance. And, employees should receive compliance training on a routine basis — this applies to employees at all levels (including upper management). Training should be performed live whenever possible, and topics should be updated and refreshed periodically to ensure that employees are kept informed of developments in a timely manner. Companies should track attendance at compliance trainings and retain attendance records centrally.

**Ensure Documentation Meets Regulatory Standards**

In its FY2016 Health and Human Services workplan, OIG stated that it would increase scrutiny of supporting documentation for claims submitted by SNFs. Going forward, in order for SNFs to show that the care provided was “reasonable and necessary,” they must maintain all resident assessment documentation required by 42 C.F.R. § 483.20. OIG noted in particular that SNFs must maintain “(1) a physician order at the time of admission for the resident’s immediate care, (2) a comprehensive assessment, and (3) a comprehensive plan of care prepared by an interdisciplinary team that includes the attending physician, a registered nurse, and other appropriate staff.”
SNFs should review their document management policies and make sure that they are compliant with regulations and these expectations. The company should be in a position to demonstrate, with documentation, how their resident assessments justify the services patients receive.

**Provide a Mechanism for Employees to Report Concerns Internally**

In addition, SNFs should ensure that they have a mechanism for employees to report concerns about care provided, billing or any other compliance issues internally, without fear of retribution. This will allow SNFs to learn of, investigate and address potential problems internally before they escalate further. Many False Claims Act investigations and cases brought against SNFs and other health care providers are initiated by employee whistleblowers who identify and alert the government to the alleged misconduct.

These measures will not fully insulate an SNF from a potential enforcement action or *qui tam* litigation, but they can mitigate the risk. Given the spate of recent enforcement actions, the eye-popping settlement figures and DOJ pronouncements that SNFs remain an enforcement priority, SNFs should consider themselves likely targets of government attention, and should proactively work to put themselves in the best position to defend against claims of misconduct.

**Endnotes**

1. Though considered separate providers for claims purposes, many facilities provide both SNF services and long-term nursing care services.


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