**The Origin of Fraud**

We hear so much about what constitutes healthcare fraud: false billing, upcoding, unbundling, kickbacks, self-referrals, substandard care, etc.

**Is the Healthcare Industry Fraudulent?**

How does fraud begin? What is its origin? Do we really have an industry of greedy professionals as the Office of the Inspector General (OIG) and the media would have us believe? Do we really have an industry comprised of dishonest human beings or of uninformed healthcare practitioners making choices that the OIG considers fraudulent? To hear the OIG speak of it, the entire healthcare industry is corrupt, just waiting for opportunities to rip off the system. I am particularly affronted by the thought that the OIG thinks healthcare practitioners are spending time and money with their lawyers dreaming up new ways to maneuver around the fraud and abuse laws and regulations in an effort to maintain high profit margins. I think not.

**Fraud Grows within a Particular Type of Corporate Environment**

I submit that true fraud, as opposed to accidental mistakes, in the healthcare industry starts and grows within a particular type of corporate environment. This corporate environment can be found throughout the provider field: physician office, long-term care nursing home, sub-acute nursing home, hospital, home healthcare agency, surgicenter, outpatient rehab nursing home, etc.

**Illustration: The Successful Long-Term Care Nursing Home**

To illustrate, let's take a long-term care nursing home in New Jersey. This particular nursing home has been successfully and quickly growing into diversified areas, including sub-acute and outpatient rehabilitation. All of this was initiated under the original Medicare cost-based reimbursement system and then moved forward under the Resource Utilization Group (RUG) payment methodology. Everything has always been going great for this nursing home. It even has a history of NJDOH deficiency-free surveys for two consecutive years.

**The Challenge: Patient Driven Payment Model**

There is, however, a problem. On October 1, 2019, Medicare implemented its latest reimbursement methodology, Patient Driven Payment Model (PDPM). Our nursing home is faced with potential reduced income if unprepared for this significant change. As it turns out, the administrator begins to worry because she is ill-prepared. She worries about the impact PDPM, coupled with Medicaid cutbacks, will have on the ability of the nursing home to sustain cash flow and to continue with its diversification projects. The administrator, however, has difficulty explaining these concerns to the Governing Body. The Governing Body is made up, primarily, of owners who are neither familiar with our industry nor familiar with day-to-day operations.

**Mismatched Expectations: Governing Body V. Administrator**

As a result, there is a mismatch of expectations. The Governing Body continues to expect growth and positive cash flow. The administrator, however, sees that growth and positive cash flow are not likely to continue, at least for a few years. For the first time in years, the administrator is facing the very real possibility of failing to meet the Governing Body’s expectations. To make matters worse, the Governing Body has clearly communicated to the administrator that its expectations must be realized. Or else!

**Fear of Failure**

Very experienced administrators in the healthcare industry would recognize that this nursing home needs to suck in its breath, tighten its belt, dig into cash reserves, and expand its revenue sources to include managed care payors. Experienced administrators would anticipate that Congress's initial overreaction in the Balanced Budget Act of 1997, followed by RUGs and now PDPM, would be met, a year or two down the road, by another overreaction but in the opposite direction in the form of relief (which is exactly what has happened in the past). But this nursing home does not have an experienced administrator. This administrator is terrified that she will not be able to meet her Governing Body’s expectations for continued growth and positive cash flow. In fact, the Governing Body is putting even more pressure on her to grow nursing home revenues, to add a new wing, and to increase the already positive cash flow. The administrator worries about failing.

**Corporate Environment: Pressure, Aggressive Targets, and "Must Do" Message**

We now have a corporate environment that includes intense pressure, aggressive targets for growth, and a clear message that the growth targets must be reached.

**The Dilemma**

The administrator, despite her lack of experience, realizes that the growth targets are not going to be reached. No way, no how. The reimbursement from Medicare is simply not going to be there, at least over the next few years. Added competition from assisted living facilities has increased the difficulty in filling beds, and admitting sicker patients costs more to provide care. Staff have already been reduced as much as possible in an effort to maximize profits. Group purchasing opportunities, too, have been maximized. What else can be done?

**Choices: Notify Governing Body or Fudge the Financials**

Our administrator has two choices: The first is to notify the Governing Body that she anticipates failing to achieve the clear goals that are demanded of her. This is, of course, totally unpalatable, especially after the success that she has enjoyed the past few years. The other choice is to fudge the financials just a bit in order to make it look like, for only this first month of PDPM, that the nursing home is on target to meet its goals. She chooses this latter option.

**Fraud: Increase PDPM Scores**

But how does she do this? She decides to meet with her director of nursing to ensure that the PDPM scores are maximized for billing purposes. After all, doesn't the nursing home have a group of newly graduated nurses? The previous experienced nurses had left to work with a local competitor. Perhaps these new nurses are not really skillful enough in maximizing legitimate opportunities to bill through the PDPM program. So the administrator meets with the director of nursing. The director of nursing gets the message loud and clear: if in doubt, maximize reimbursement PDPM, and work out the supporting documentation later, if necessary. This seems to work. Invoices go out with increased charges, and the nursing home population, when looked at from a PDPM perspective, appears to be getting the amount of care that it deserves. The administrator is pleased because the Governing Body is pleased.

**Fraud: Works at First but Then Makes Matters Worse**

For the first month after PDPM is introduced, this approach appears to work. In fact, what started out as a strategy for the month only has now spread into the second and third months. The administrator found it difficult to rescind her directive to the director of nursing once the increased revenues begin to flow into the nursing home. The administrator also thought the other strategies, including increasing revenue from managed care payors, would have worked by now. The other strategies have not worked. Unfortunately, because of PDPM, something beyond the administrator's control, cash flow continues to weaken, albeit at a slower rate of decline had the administrator not taken her extraordinary steps. So, despite the potential increases in PDPM, PDPM continues to have its effect. But now, not only is there the anticipated decreased cash flow problem, but there is also a new problem in having inappropriately increased the documentation to support PDPM reimbursement claims.

**Fraud: The Problems Become Compounded by PDPM**

The administrator begins to worry. How likely is it that the OIG will knock on her door during this, the fourth month? Or ever, for that matter? She did hear, however, that a nursing home in the northern part of New Jersey was recently visited by the OIG, and the investigation was not pretty. Nevertheless, she decides that her more immediate concern is meeting the expectations of the Governing Body. But she is now into the start of the fourth month and her revenues are continuing to drop despite her best efforts and, as she now admits to herself, she has instituted an unlawful strategy for maximizing PDPM reimbursement. She also realizes that the outcome of the MDS submissions has shifted from a payment system which rewards higher therapy use (RUGs) to a system that is focused on nursing care. The functional status of each resident is less controllable because nursing is now just as important as rehabilitation was under RUGs. In the past it would have been enough to rely upon the cooperation of the rehabilitation director in upcoding therapy minutes. Now, she needs to rely on both the director of nursing and many professionals in the nursing department to create documentation designed to maximize and even enhance the impact of data recorded in a revised version of the MDS, Section GG, Functional Abilities and Goals.

**Fraud: The Periodic Behavior Becomes a Consistent Pattern of Behavior**

The administrator further becomes alarmed by her suspicion that the nurses have stopped struggling with the question of what the proper documentation is to support PDPM and are, instead, automatically adding documentation whether the appropriate additional care was provided or not. She realizes that under the PDPM payment system, functional performance score of each resident influences the level of payment for physical therapy, occupational therapy, and nursing services. She is very concerned that at this point, all departments have impact on database content that produces the qualifying payment levels. She is losing control.

**Fraud: The Treadmill Effect**

As the fifth month begins after the administrator started "fudging the financials just a bit," the administrator is panicking. She finds herself facing continued cash flow declines and possible patterns of intentional misrepresentations in the nursing department. To make matters worse, the outside accounting auditors are coming in shortly to do the periodic financials. Surely they will see what has happened. She finds herself instructing her director of nursing to personally change the patient's medical records in order to support the higher PDPM reimbursement. More and more, the administrator feels as if she is on a treadmill. She has to run faster and faster in order to just stay where she is.

**Fraudulent Participation: Now Includes the Accounting and Rehab Departments**

Let's step back to see what has happened at this point. What started out as just the administrator's efforts to maximize billing during the first month has spread to include fraudulent participation by the nursing department and, unknowingly, by the accounting department staff who submit the claims. The nursing home is ripe for a qui tam (whistleblower) action to be filed or, with more immediate and severe consequences, a telephone call to be made directly by an anxious employee to the OIG. The nursing staff, and especially the director of nursing, all know they are doing something wrong. They are all anxious about the pressure they are under to continue their patterns of fraud and yet are even more anxious about getting caught. After all, they have their families and careers to be concerned with. What started out as a way to help the administrator and the nursing home they care about has turned into serious issues of potential civil and criminal liability. Unfortunately, these employees have now participated in what will clearly be considered fraud. They are all in too far to extricate themselves.

**The Administrator Considers an Exit Strategy**

This nursing home does not have a compliance and ethics program. If it had such a program, at least two of the seven elements would have prevented, or at least mitigated, the damages of this fraudulent behavior. First, an auditing system would have been in place to review medical records, and compare with the actual care provided, as well as compare to the billing statements. Second, there would be the availability of a Compliance and Ethics Officer to whom these anxious employees could turn with their concerns. Unfortunately, this nursing home does not have such a program. The Governing Body had earlier declined to put such a plan in place because it believed it had an honest staff of employees. But now the administrator is looking for an exit strategy of some sort. In addition to her fear of the inaccurate PDPM and its impact on revenue, she knows that effective November 28, 2019, state surveyors began assessing the implementation and effectiveness of nursing home compliance and ethics programs.

**Corporate Compliance and Ethics Plan: Too Late**

The administrator calls a healthcare attorney who specializes in developing and implementing corporate compliance and ethics programs. She explains briefly and desperately that the nursing home provides good care for its residents and is run by honest people, but that she nevertheless recognizes the need to have a corporate compliance and ethics program in place should the OIG ever knock on the door, and to also satisfy the state survey team. She confirms with the healthcare attorney that such a compliance and ethics program, if effective, may minimize any civil and criminal penalties should the government impose such penalties on a nursing home. The healthcare attorney agrees to begin work immediately. However, before the attorney can begin her assignment, the dam breaks.

**The OIG: Busted**

The word gets out to the OIG that something is wrong and that altered documents are about to be destroyed. The administrator is faced early one morning with FBI agents, brandishing guns, holding out search and seizure warrants for all patient data. Computers are loaded into the backs of trucks. Filing cabinets are carted off. Medical records by the cartload are taken away. Anything of questionable value to the investigation is taken. The nursing home is left in a complete financial and clinical shambles. The attorney who was called in to begin a compliance program, having just arrived, is standing at the front door, helpless to intercede and realizing the administrator's effort to initiate a corporate compliance and ethics program was too little, too late.

**Conclusion: Why Bad Things Happen to Good Providers**

1. Fraud does not start with dishonesty.
2. Fraud starts with pressure.
3. Fraud starts out one small step at a time.
4. Fraud starts with areas that might be considered by some to be areas of "gray".
5. Fraud increases, in its complexity and scope, over a long period of time.
6. Fraud locks its participants in so that there is no escape.

**The Solution: Corporate Compliance and Ethics Plans**

Fraud starts out with good intentions: to continue to build the organization and to continue to provide jobs for the employees. But the slope is slippery from there. What often begins as a one-person effort eventually involves many people in the organization. A corporate compliance and ethics program, seriously initiated, implemented, and maintained, is the only way to ensure that nascent fraud does not begin and spread throughout an organization. Once fraud begins and spreads throughout an otherwise "honest" organization, without the benefit of a corporate compliance and ethics program in place, the only option often available to the organization is to confess. The organization must seriously consider approaching the OIG before the OIG and/or the Justice Department (on the basis of a qui tam action) approaches the organization.