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Leveraging CIAs as a compliance tool: Analyzing trends to identify and mitigate compliance risks for post-acute care providers

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Identifying, monitoring, and addressing potential risk areas is a critical component of an effective compliance program. Indeed, the U.S. Department of Health & Human Services Office of Inspector General (OIG) recommends that healthcare organizations participating in federal healthcare programs conduct periodic risk assessments and engage in internal review processes with the aim of identifying and prioritizing risks, developing and implementing internal audit work plans related to such risks, and developing and implementing corrective action plans in response to the results of any such audits.[1] Identifying potential risks requires that compliance personnel understand the organization's operations and review and consider numerous sources of information to determine the possible compliance challenges that could result in legal, financial, or reputational harm. Understanding government enforcement trends enables healthcare organizations to make informed decisions regarding where to invest their time, energy, and resources.

This article is the third in a series designed to equip compliance personnel with data—derived from recent government enforcement activity—that can help them better understand the government's current enforcement priorities and, thus, more easily identify and rank potential risks to their organization.

Recent corporate integrity agreements (CIAs) and integrity agreements (IAs) imposed by the OIG,[2] and the associated settlement agreements and litigation filings provide a wealth of information regarding the agency's priorities, areas of focus, and compliance expectations.[3] (IAs are similar to CIAs but typically have a shorter term and contain fewer compliance obligations.) By understanding the circumstances under which the OIG has imposed a CIA or IA, federal healthcare program participants can better understand the agency's enforcement emphasis and identify internal practices that may require closer scrutiny.

Unfortunately, while the OIG maintains a publicly available database of its active CIAs and IAs (and associated materials),[4] the data is not organized in a way that easily allows for quantitative and qualitative analysis. Each article in this series is designed to provide targeted data analysis of recent CIA and IA enforcement activity related to a specific type of provider or supplier. This article focuses on recent CIAs involving post-acute care providers.

Trends among CIAs involving post-acute care providers

During the period from January 1, 2020, through October 15, 2021, the OIG imposed seven CIAs on post-acute care providers and made substantive amendments to a CIA that had been imposed on a post-acute provider in 2018. Six of the newly imposed CIAs, as well as the amended CIA, involved skilled nursing facilities (SNFs) (further defined as SNF CIAs). The remaining CIA involved a hospice provider (Hospice CIA).

All of these CIAs were imposed in connection with a Department of Justice (DOJ) settlement of one or more actions brought under the federal civil False Claims Act. Notably, several of these settlements also included a state attorney general and/or other state authorities as parties settling actions brought under the state equivalent of the False Claims Act for claims submitted to the state's Medicaid program.

A study of the SNF CIAs and Hospice CIA noted above, as well as the corresponding DOJ news releases, settlement agreements, and underlying complaints detailing the actions at issue (to the extent publicly available), reveals certain trends that may be of interest to compliance personnel. Our analysis provides insights into potential risks arising from, among other things, (i) the adequacy and medical necessity of care provided to post-acute care patients, (ii) the quality of care provided to post-acute care patients, and (iii) clinical eligibility for hospice services. The specific allegations underlying these CIAs, and the associated compliance obligations imposed through them, can be leveraged as valuable informational tools for post-acute care providers when developing risk management and compliance strategies.

Alleged false claims for ultra-high rehabilitation therapy furnished to SNF residents

All of the SNF CIAs arose, in large part, from allegations that the SNFs provided therapy services that were not medically necessary or reasonable to maximize Medicare reimbursement.

As background, the Centers for Medicare & Medicaid Services (CMS) makes Medicare payments to SNFs on a per diem basis, with the per diem payment rate covering the cost of all covered SNF services furnished to the Medicare beneficiary (subject to limited exceptions).[5] For each Medicare beneficiary, the per diem payment rate is equal to a federal base rate subject to specified adjustments, including, in relevant part, an adjustment based on the SNF's case mix (i.e., differences in patient types).[6]

From October 1, 2010, to September 30, 2019, this case mix adjustment was determined in accordance with a Resource Utilization Groups (RUGs), Version IV (RUG-IV) model.[7] Under the RUG-IV model, Medicare beneficiaries were assigned to a therapy resource utilization group based on (i) the total number of therapy minutes—for physical therapy, occupational therapy, and speech therapy—provided by the SNF to the patient during an assessment period and (ii) the patient's "activities of daily living" (ADL) score for bed mobility, transfer, eating, and toilet use. This therapy RUG assignment, in turn, typically would affect the per diem payment amount received by the SNF for that beneficiary. Under the RUG-IV model, the most intensive (and hence highest reimbursing) therapy RUG category was ultra-high rehabilitation. Within this ultra-high rehabilitation therapy RUG category, one of three RUG codes could be assigned, which varied based on the patient's ADL score, and which could affect the reimbursement to the facility. All three of the ultra-high rehabilitation therapy RUGs required that the SNF provide to the beneficiary 720 minutes of therapy in at least two therapy disciplines (i.e., physical therapy, occupational therapy, or speech therapy) during an assessment period, as reported on the patient's Minimum Data Set (MDS).[8] The MDS is a standardized care assessment tool used by SNFs to assess the patient's condition as it relates to issues such as hearing, speech, and vision; cognitive patterns; mood; behavior; functional abilities and goals; bladder and bowels; active diagnosis; health conditions; swallowing and nutritional status; skin conditions; medications; and special treatments, procedures, and

programs.[9]

For all six of the newly imposed SNF CIAs, as well as the amended SNF CIA, the alleged conduct took place prior to October 1, 2019, when this RUG-IV model was still in place. The SNFs were alleged (directly or through their corporate parents) to have implemented policies and engaged in practices designed to maximize the number of SNF residents billed at the ultra-high rehabilitation therapy RUG level. The alleged result was that the SNFs furnished therapy that was neither reasonable nor necessary for the patient in order to meet this billing goal. Although the specific policies varied, they generally involved alleged company-wide quotas, budgets, or targets that put pressure on SNFs, and therapists in particular, to classify residents at the ultra-high rehabilitation therapy RUG level without regard to the resident's actual conditions, diagnoses, or needs. Of particular note:

- At least four of the SNF CIAs involved assertions that the SNFs were required by their corporate parents to assign some portion of current or newly admitted residents to the ultra-high rehabilitation therapy RUG level, regardless of the resident's individual needs.[10] For example, one corporate owner allegedly mandated that its SNF facilities assign 70% of newly admitted residents to the ultra-high rehabilitation therapy RUG level; two others allegedly required *all* newly admitted residents to be assigned to this level.[11]

- Three of the SNF CIAs involved allegations that the SNFs' corporate owners set unrealistic targets and quotas for therapists. One company, for instance, allegedly required therapists to provide billable services 90% of the time they were at the SNF.[12] The relator argued that such a mandate left little time for therapists to conduct nonbillable services, such as patient notes, and caused therapists to bill group therapy as individual sessions to increase their productive time. Another company was alleged to have corporate policies that tied therapist productivity to the amount of time the therapist spent on Medicare billable work, which allegedly caused therapists to report unbillable time for things such as their initial patient evaluations and time spent providing unskilled services as skilled therapy time.[13] A third company allegedly pressured therapists to increase the amount of therapy provided to patients by setting a goal that 100% of Medicare Part A patients would be prescribed rehabilitation therapy.[14]

- Some of the corporate entities also allegedly assigned SNF budgets based on a presumption that a majority of the SNF's Medicare Part A patients would be billed at the ultra-high rehabilitation therapy RUG level, putting pressure on the SNF to achieve such targets.[15]

- In at least one instance, the corporation's officers and the SNF's administrative staff instructed nursing staff to reassess patients in order to increase their ADL scores, thus increasing their resulting RUG level and overall billing. Nurses who did not comply were threatened with termination.[16] Two of the SNF CIAs also involved allegations that nonclinical corporate employees overrode and ignored the recommendations of the SNF therapists and other clinical staff, including by delaying the resident's discharge to extend the length of stay, thereby increasing reimbursement.[17]

Some of the SNF CIAs also included allegations of "thresholding" (i.e., claims that the SNF provided just enough therapy minutes for the Medicare beneficiary to qualify for the higher RUG level). CMS noted this trend as early as 2014, when it published a finding that ''the percentage of claims-matched MDS assessments in the range of 720 minutes to 739 minutes, which is just enough to surpass the 720 minute threshold for RU groups, has increased from 5 percent in FY 2005 to 33 percent in FY 2013."[18] The SNF CIAs noted in this article demonstrate the continued trend of thresholding since that time. For example, one SNF CIA involved assertions that a SNF's "Rehabilitation Service Managers" set or adjusted the length of patients' daily therapy sessions based upon the

number of minutes needed to reach the targeted RUG level, despite the fact that these individuals were unfamiliar with the patients' therapy needs.[19] Similarly, two other SNF CIAs allegedly monitored the amount of therapy provided to residents billed at the ultra-high rehabilitation therapy RUG to ensure that therapy beyond the required 720 minutes was not provided.[20] For instance, one company allegedly circulated "overage" reports reflecting the amount of therapy provided above a particular RUG threshold, with corresponding emails explaining that the SNF is "not being paid to provide excess [therapy] minutes."[21]

These SNF CIAs also included allegations that the SNFs (directly or through their corporate owners):

- Recorded therapy minutes as individual therapy when concurrent or group therapy was provided to increase the amount of therapy minutes attributable to each resident for billing purposes;[22]
- Provided unskilled services performed by skilled therapists in order to bill as skilled therapy;[23]
- Billed for services that were never provided to ensure patients remained at the ultra-high rehabilitation therapy RUG level;[24]
- Included unbillable time spent on initial evaluations as part of the reported therapy time;[25]
- Arbitrarily shifted the number of minutes between different types of therapy disciplines to ensure that the ultra-high rehabilitation therapy requirements were met;[26]
- Adjusted patient assessments to increase the amount of therapy minutes prescribed solely to increase RUG levels;[27] and
- Inflated resident ADL scores.[28]

The allegations underlying these SNF CIAs appear to be representative of longstanding concerns raised by the OIG and the Medicare Payment Advisory Commission, an independent congressional agency, regarding how the RUG-IV model created financial incentives for SNFs to bill for more therapy services than medically necessary.[29] To "better align" the SNF payment system with "resource use," and to eliminate the "therapy provision-related financial incentives inherent" in the RUG-IV model, CMS replaced the RUG-IV model with a revised case-mix methodology, referred to as the Patient-Driven Payment Model (PDPM), effective October 1, 2019.[30] Under the RUG-IV model, a SNF reduced everything about a patient into a single case-mix based upon the volume of care needed—the RUG level. The PDPM model is designed to be more flexible to an individual patient's needs by classifying the patient within each of five different case-mix components—physical therapy, occupational therapy, speech-language pathology, nursing, and nontherapy ancillary services.[31] Each case-mix component considers different criteria about the patient's various characteristics in order to make the necessary classification. For example, a patient's classification under the physical therapy and occupational therapy case-mixes each consider the patient's clinical category (i.e., diagnosis) and functional score (as reported in Section GG of the MDS), while the patient's classification under the speech-language pathology case-mix considers whether the patient has any acute neurological conditions, cognitive impairments, swallowing disorders, or speech-language pathology–related comorbidities. The various case-mix classifications are then used to predict the overall therapy costs associated with the individual patient's medical need. In sharp contrast to the RUG-IV model, none of the case-mix components under the PDPM model consider the number of therapy minutes provided.

While the RUG-IV model is no longer in place, the SNF CIAs discussed above still provide valuable compliance

insights, which are discussed in more detail below.

Alleged false claims of substandard services

One of the SNF CIAs also involved the alleged provision of substandard or worthless skilled nursing services. Specifically, the allegations involved a failure to (i) appropriately administer medications to some residents, (ii) follow appropriate pressure ulcer protocols, and (iii) abide by protocols to avoid falls.[32] In addition, the SNFs allegedly had insufficient staffing to meet the residents' needs. According to one relator, the corporate entity that owned and managed the SNFs implemented a company-wide staffing policy that restricted staffing at all SNFs to an average of 1.93 hours allotted per day per patient/resident, regardless of the residents' needs and despite a congressional report suggesting such per day per patient/resident levels were "known to cause widespread and significant care deprivation."[33]

Once again, the allegations underlying this SNF CIA appear to be representative of broader government concerns regarding quality of care in the nursing home industry. On March 3, 2020, more than a year before the SNF CIA was imposed, DOJ announced a National Nursing Home Initiative to enhance civil and criminal enforcement against nursing homes that provide "grossly substandard care" to their residents.[34]

Alleged false claims for medically unnecessary hospice services

Similar to some of the alleged conduct discussed above relating to ultra-high rehabilitation therapy, the sole Hospice CIA arose from allegations that the hospice provider (i) billed for patients who were ineligible to receive hospice services under Medicare requirements, and (ii) billed Medicare, Florida Medicaid, and TRICARE for higher levels of care that were not medically necessary.[35]

The hospice benefit under Medicare (which is a per diem payment) covers a range of services for "terminally ill" patients, defined as individuals who have received a medical prognosis that their life expectancy is six months or less.[36] The hospice provider allegedly billed Medicare for at least 48 consecutive months of hospice care, during which time the patients were not eligible for the Medicare hospice benefit because, for at least a portion of the time, they were not terminally ill.[37]

Additionally, the hospice allegedly provided care that was not medically necessary. Medicare, Medicaid, and TRICARE reimburse for four different levels of hospice care: routine home care, continuous home care, inpatient respite care, and general inpatient care (GIP). GIP is intended for patients who require symptom or pain management that cannot be managed in other settings. As the most intensive kind of hospice care, it is intended to be short term and is reimbursed at the highest level. According to the federal government and relator, the hospice billed at least 15 consecutive days of GIP hospice care in circumstances where patients did not require this level of care for at least a portion of the time, resulting in services that were not medically necessary or reasonable.[38]

Potential compliance activities based on CIAs imposed on post-acute care providers

The trending consideration throughout each of the CIAs discussed in this article is whether post-acute care patients are receiving appropriate levels of adequate and necessary care. Although there has been a change to the reimbursement model for SNFs, this same consideration should still be a focus for all post-acute care providers when performing risk assessments and related monitoring and auditing activities.

Potential compliance activities for SNFs

Whereas the fraud and abuse concerns underlying the RUG-IV model often related to the overutilization of therapy for patients whose medical needs did not align with the amount of therapy required in order to meet the ultra-high rehabilitation therapy RUG threshold, under the PDPM model, there is a concern that SNFs may engage in "stinting" (i.e., providing patients with less therapy than their medical needs require).[39] While the SNF CIAs were imposed due to alleged fraud and abuse in connection with the RUG-IV model, they include safeguards aimed at addressing potential fraud and abuse concerns under the new PDPM model. For example, Appendix B of these SNF CIAs task an independent review organization with (i) reviewing the controls the SNF has in place to ensure that items and services billed to Medicare Part A are "medically necessary and reasonable, appropriate and sufficient to meet the needs of a patient in the assigned Case Mix Groups, and appropriately documented," and (ii) performing a claims review that examines (among other things) the total number and percentage of instances in which a paid claim was for items and services that were not "appropriate and sufficient to meet the needs of a patient in the assigned Case Mix Groups."[40]

To address these potential fraud and abuse concerns (i.e., to ensure patients are receiving appropriate levels of therapy), SNFs may wish to consider the following compliance activities:

- Developing procedures for continual evaluation and documentation of patient therapy levels based upon the documented medical needs of the individual patient;
- Educating therapy staff on documenting the reason for any reduction or change in the level or type of therapy services provided to each patient within the patient's plan of care;
- Reviewing policies and goals established for therapists to ensure that goals are not tied to Medicare reimbursement levels and that therapists are free to assess therapy levels based upon the patient's independent medical needs;
- Monitoring shifts in overall coding and MDS reporting patterns, including primary and secondary diagnoses codes, comorbidities and functional abilities, and, if determined to be warranted, conducting a pre-bill review to confirm the codes and functional scoring reported on the MDS is appropriately supported by underlying clinical documentation; and
- Conducting periodic audits of MDS reports, especially functional abilities and goals reported in Section GG, to ensure the information reported is supported by adequate documentation in the patient's medical record and to identify any potential patterns or weaknesses that may warrant a more in-depth review or additional staff education and training.

As reflected in the previous section, some of the SNF CIAs involved allegations of concurrent or group therapy inappropriately being used in lieu of individual therapy. This continues to be a concern under the new PDPM model, as providers are permitted to provide up to 25% of a resident's total therapy in a concurrent or group therapy setting, which may provide the patient with less individualized care than the patient would otherwise need.[41] Although the current rules permit this level of concurrent or group therapy, the continued expectation by CMS is that the patient's individual medical needs will always dictate the level of services provided, and CMS has indicated that it will continue to monitor concurrent and group therapy levels. Facilities that exceed the 25% limit will receive a "warning edit," and consistent violation of the limit may result in the facility being flagged for additional medical review.[42] CMS has also stated that it may revisit the idea of a penalty for exceeding the 25% limit in the future. As a result, SNFs should evaluate their policies regarding concurrent and group therapy and their rules for determining the level of concurrent or group therapy provided to each patient. SNFs also

should educate therapy staff on documenting the specific rationale for changes to a patient's concurrent or group therapy level within the patient's plan of care.

Potential compliance activities for hospice providers

As illustrated by the Hospice CIA, it is critically important for hospice providers to ensure they have adequate documentation supporting the patient's terminal diagnosis, including documentation that establishes why the patient's life expectancy is six months or less, and that the level of hospice services provided is supported by medical necessity. To that end, hospice providers may wish to consider the following compliance activities:

- Developing and/or reviewing pre-admission processes for documenting hospice eligibility, including physician certification and medical record documentation that adequately describes why the patient's life expectancy is six months or less;
- Reassessment and documentation of patient's hospice eligibility in connection with each recertification period, including a pre-bill review of documentation of a face-to-face encounter with the patient's provider, signed and dated certification, and documentation in the patient's medical record of the provider's clinical findings to support continued hospice eligibility; and
- Conducting a pre-bill review of a sample of GIP services to ensure that the medical record supports medical necessity and reasonableness.

Potential compliance activities for all post-acute care providers

As a final note, as illustrated by the SNF CIA involving allegations of substandard services and the related DOJ National Nursing Home Initiative, ensuring quality of care is a government enforcement priority. To address that issue, it may be advisable for any type of post-acute care provider to regularly review their written policies and procedures for their nursing staff as well as all training and assessment programs to ensure the quality of care provided by their nursing staff is consistently monitored. Post-acute providers also may wish to closely monitor staffing levels to ensure that sufficient nursing staff are available to meet the level of care required for the provider's current patients. In the event that staffing shortages arise, the provider may wish to document all action taken to address the shortage in a timely manner.

Conclusion

As made clear by the SNF CIAs and Hospice CIA discussed above, government enforcement in this area is focused on ensuring that post-acute care providers are providing, and billing for, care that is medically necessary and reasonable. Consideration of CIA enforcement can highlight areas of potential risk to post-acute care providers and help their compliance teams develop an effective compliance program tailored to address these critical areas.

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Takeaways

- Corporate integrity agreements imposed on post-acute providers, such as skilled nursing facilities (SNFs) and hospice providers, highlight government enforcement priorities, serving as a useful risk assessment and compliance planning tool.
- Corporate integrity agreements (CIAs) recently imposed on SNFs reflect an ongoing government concern regarding whether SNF residents are receiving appropriate levels of adequate and necessary care. Although

some of the financial incentives for SNFs have shifted since the imposition of the SNF CIAs, ensuring that adequate therapy levels are provided to SNF residents remains critical for ensuring compliance with federal healthcare program requirements.

- Based on recent SNF CIAs, as well as other guidance from the federal government, quality of care appears to be a continued area of government scrutiny.
- A CIA recently imposed on a hospice provider illustrates concerns about clinical eligibility for hospice services and whether general inpatient care services are supported by medical necessity.
- To address these potential risks, post-acute care providers may wish to consider a review of existing policies and processes, as well as development of appropriate new policies and procedures when indicated; targeted training programs for clinical personnel; and targeted pre-bill reviews.

1*See* Publication of the OIG Compliance Program Guidance for Nursing Facilities, 65 Fed. Reg. 14,289, 14,291 (March 16, 2000); Publication of the OIG Compliance Program, Guidance for Hospices, 64 Fed. Reg. 54,031, 54,034 (October 5, 1999); HCCA-OIG Compliance Effectiveness Roundtable, *Measuring Compliance Program Effectiveness: A Resource Guide*, March 27, 2017, https://oig.hhs.gov/documents/toolkits/928/HCCA-OIG-Resource-Guide.pdf.
2 The decision of whether a CIA or IA will be imposed typically depends on the size of the provider at issue. According to frequently asked questions published by the OIG, IAs are imposed on individual practitioners, small group practices, and small providers. *See* "Corporate Integrity Agreement FAQ," Office of Inspector General, U.S. Department of Health & Human Services, accessed December 21, 2021, https://oig.hhs.gov/faqs/corporate-integrity-agreements-faq.asp.
3*See* Publication of the OIG Compliance Program Guidance for Hospitals, 63 Fed. Reg. 8,987, 8,994 (February 23, 1998); OIG Supplemental Compliance Program Guidance for Hospitals, 70 Fed. Reg. 4,858, 4,875 (January 31, 2005); The Office of Inspector General of the U.S. Department of Health & Human Services and The American Health Lawyers Association, *Corporate Responsibility and Corporate Compliance: A Resource for Health Care Boards of Directors*, accessed December 16, 2021, 4–5, https://oig.hhs.gov/fraud/docs/complianceguidance/040203CorpRespRsceGuide.pdf.
4 "Corporate Integrity Agreement Documents," Office of Inspector General, U.S. Department of Health & Human Services, last updated December 17, 2021, https://oig.hhs.gov/compliance/corporate-integrity-agreements/cia-documents.asp.
5*See* 42 U.S.C. § 1395yy.
642 U.S.C. § 1395yy(e)(4)(G).
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10 Complaint, United States ex rel. Saffarian et al. v. Encore Rehab. Servs. LLC, No. 1:16-cv-605 (W.D. Mich. July 10, 2019) (Encore Saffarian Complaint), ¶ 7(a)–(b); Complaint, United States ex rel. Wright et al. v. Saber

Healthcare Holdings LLC, No. 2:16-cv-640 (E.D. Va. Nov. 1, 2016) (Saber Complaint), ¶ 6(b)-(d); Complaint, United States ex rel. Emerson v. Signature HealthCARE LLC, No. 1:15-cv-00027 (M.D. Tenn. Mar. 27, 2015) (Signature Complaint), ¶ 77; Settlement Agreement, United States ex rel. Emerson v. Signature HealthCARE LLC, No. 1:15-cv-00027 (M.D. Tenn. May 29, 2018) (Signature Settlement Agreement) ¶ D(1)–(2); Consolidated Complaint in Intervention, United States ex rel. Hayward v. SavaSeniorCare LLC, No. 3:11-cv-0821 (M.D. Tenn. Oct. 16, 2015) (Sava Consolidated Complaint in Intervention), ¶¶ 87, 121.

11 Encore Saffarian Complaint, ¶ 7(a)–(b); Saber Complaint, ¶ 29; Signature Settlement Agreement ¶ D(2).

12 Encore Saffarian Complaint, ¶ 12; Complaint, United States ex rel. LaFerriere v. Encore Rehab. Servs. LLC, No. 1:17-cv-95 (W.D. Mich. Jan. 27, 2017), ¶ 2.

13 Saber Complaint, ¶¶ 7, 210–219; Settlement Agreement, United States ex rel. Wright et al. v. Saber Healthcare Holdings LLC, No. 2:16-cv-640 (E.D. Va. Mar. 31, 2020), ¶ D.

14 Complaint, United States ex rel. Pennetti v. Longwood Management Corp., No. CV-14-4133 (C.D. Cal. May 29, 2014) (Longwood Pennetti Complaint), ¶¶ 61–63.

15 Signature Settlement Agreement ¶ D(1).

16 Complaint, United States ex rel. Haggard v. Diversicare Mgmt. Services Co., No. 3:12-cv-00669 (M.D. Tenn. July 3, 2012) (Diversicare Haggard Complaint), ¶ 30.

17 Sava Consolidated Complaint in Intervention, ¶¶ 63, 101, 174; Complaint, United States ex rel. Krauss v. Guardian Elder Care Holdings, Inc., No. 3:15-cv-6850 (E.D. Pa. Dec. 30, 2015) (Guardian Complaint), ¶ 2.

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19 Signature Complaint, ¶¶ 53–54.

20 Sava Consolidated Complaint in Intervention, ¶ 137; Guardian Complaint, ¶ 7.

21 Sava Consolidated Complaint in Intervention, ¶¶ 139–144.

22 Complaint, United States ex rel. Anderson v. Encore Rehab. Servs. LLC, No. 2:14-cv-13759 (E.D. Mich. Sept. 29, 2014), ¶¶ 7, 99-102; U.S. Department of Justice, "Contract Rehab Provider to Pay $4 Million to Resolve False Claims Act Allegations Relating to the Provision of Medically Unnecessary Rehabilitation Therapy Services," news release, April 10, 2020, https://www.justice.gov/opa/pr/contract-rehab-provider-pay-4-million-resolve-false-claims-act-allegations-relating-provision.

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24 Diversicare Settlement Agreement, ¶ D; Signature Complaint, ¶¶ 56, 68.

25 Signature Settlement Agreement ¶ D(8).

26 Guardian Complaint, ¶ 7.

27 Longwood Pennetti Complaint, ¶¶ 89–92; United States ex rel. Boyce v. Aegis Therapies Inc., No. CV-16-8050 (C.D. Cal. Oct. 28, 2016), ¶¶ 55–56.

28 Diversicare Haggard Complaint, ¶ 4; Guardian Complaint, ¶ 7.

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40*See, e.g.*, U.S. Department of Health & Human Services, Office of Inspector General, "Diversicare Healthcare Services, Inc. Corporate Integrity Agreement," February 14, 2020, https://oig.hhs.gov/fraud/cia/agreements/Diversicare_Healthcare_Services_Inc_02142020.pdf.
41 Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (SNF) Final Rule for FY 2019, 83 Fed. Reg. 39,237–239.
42 Centers for Medicare & Medicaid Services, "Patient-Driven Payment Model: Frequently Asked Questions (FAQs)," last revised August 27, 2019, 31, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM#faq.