Administrator Program
Tuesday, November 16, 2020
10:00am-11:30am

5a. Fraud, Waste and Abuse

Presented by:

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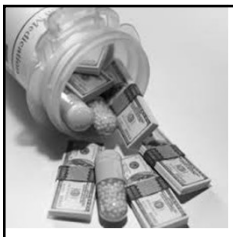

FRAUD, WASTE & ABUSE AND YOUR MARKETING PRACTICES

Texas Association for Home Care & Hospice (TAHC&H)
Administrator Conference

Tuesday, November 16, 2021

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Agenda

- Review of Anti-kickback statute
- Review of Stark law
- Review of other potentially relevant federal statutes
- Other guidance
- Review of relevant Texas laws and guidance
- Discussion of problematic marketing practices
- Compliance tips

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Anti-kickback Statute

- 42 USC § 1320a-7b(b)
- Prohibits the solicitation, offer, paying, or receipt of remuneration in exchange for or to induce the referral of beneficiaries of federal health care programs
- Criminal statute plus fines
- Bipartisan Budget Act of 2018, signed Feb. 9, 2018, increased penalties from $25,000 to $100,000 per violation
- BBA increased maximum term of imprisonment from 5 to 10 years
- Also may be excluded
- Remuneration = anything of value

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Anti-kickback Statute

- "One purpose" rule – even if lots of other (valid) reasons for remuneration, if even one purpose is to improperly induce referrals, there is a violation
- Need to show intent to violate statute
- Safe harbors – 25 safe harbors currently
  - Must meet all terms/criteria of safe harbor for it to apply
  - Commonly used safe harbors: bona fide employees, personal services and management contracts, space lease, equipment lease, practitioner recruitment, ambulance replenishment, electronic health records items and services, electronic prescribing items and services, and investment interests
  - New safe harbors added periodically

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Stark Law (Physician Self-Referral Prohibition)

- 42 US § 1395nn
- Prohibits physician referral of patient for "designated health services" to an organization in which the physician or an immediate family member has a financial relationship (ownership, investment or compensation)
- Civil statute
- Penalties – denial of payment for the DHS, refund of amounts paid, civil penalties of $15,000 for each improper service, treble damages, exclusion
- Exceptions – similar to safe harbors under AKS
- Commonly used exceptions: preventive screenings and immunizations, electronic prescribing items and services, electronic health record items and services, nonmonetary compensation of up to $407, fair market value compensation or payments, compliance training, certain indirect compensation arrangements, publicly traded securities, office space lease, equipment lease, bona fide employment relationships, physician recruitment, and isolated transactions

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Stark law

No need to prove intent; "technical violations" are still violations

12 Designated health services:

- Clinical laboratory services
- Physical therapy
- Occupational therapy
- Radiation therapy
- Durable medical equipment
- Prosthetics and orthotics
- Home health services
- Outpatient prescription drugs
- Radiology, including MRI, CAT and ultrasound
- Parenteral and enteral nutrition
- Inpatient and outpatient hospital services
- Outpatient speech-language pathology services

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Other statutes – Federal False Claims Acts

- Civil False Claims Act, 42 USC §§ 3729-3731
- Criminal False Claims Acts, 18 USC § 287
- Also False Statements, 42 USC § 1320a-7b(a)
- Prohibit knowingly submitting false claims or making false statements
- Penalties: $5,000 - $10,000 per claim plus three times amount of claim
- Prison up to 5 years
- Authorizes whistleblower lawsuits ("qui tam" lawsuits)

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Other federal guidance – OIG compliance guides

- OIG has issued numerous guidances on implementing compliance programs in various health care fields
- August 1998 – Compliance Program Guidance for Home Health Agencies, https://oig.hhs.gov/authorities/docs/cpghome.pdf
- October 1999 – Compliance Program Guidance for Hospices, https://oig.hhs.gov/authorities/docs/hospicx.pdf
- March 1998 – OIG Special Fraud Alert Fraud and Abuse in Nursing Home Arrangements with Hospices, https://oig.hhs.gov/compliance/alerts/index.asp
- August 1995 – OIG Special Fraud Alerts: Home Health Fraud, https://oig.hhs.gov/compliance/alerts/index.asp

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OIG Compliance Program Guidance Home Health Agencies

- Compliance Guidance discusses numerous potential risk areas potentially related to marketing, e.g.:
  - Improper patient solicitation activities and high-pressure marketing of uncovered or unnecessary services
    - e.g., free gifts or services to patients and non-deceptive and clear marketing information
  - Improper influence over referrals by hospitals that own home health agencies
    - e.g., improper steerage
  - Services provided to patients who reside in ALFs
    - e.g., space rental that does not meet safe harbor, and provision of services that are otherwise covered under the resident contract or required under state licensure

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OIG Compliance Program Guidance Home Health Agencies – Cont'd

- "The home health agency does not offer or provide gifts, free services, or other incentives to patients, relatives of patients, physicians, hospitals, contractors, assisted living facilities, or other potential referral sources for the purpose of inducing referrals in violation of the anti-kickback statute, Stark …, or similar Federal or State statute or regulation"
  - Consider having legal counsel review all contracts
  - Compliance officer is tasked with ensuring that contractors and agents furnishing services to the agency or clients of the agency are aware of requirements of home health agency's compliance program with respect to marketing
    - especially important with respect to independent contractors responsible for marketing activities

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OIG Compliance Program Guidance Home Health Agencies – Cont'd

- "Targeted training should be provided to corporate officers, managers, and other employees … such as employees involved in … marketing processes."
  - Topics should include general prohibitions on paying or receiving remuneration to induce referrals. Compliance officer is tasked with ensuring that contractors and agents furnishing services to the agency or clients of the agency are aware of requirements of home health agency's compliance program with respect to marketing
    - especially important with respect to independent contractors responsible for marketing activities
- Audits should be designed to address the home health agency's compliance with laws governing kickback arrangements, the physician self - referral prohibition and, among other things, *"marketing"*

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OIG Special Fraud Alert: Home Health Agencies – August 10, 1995

Concerns and cited activities of which OIG stated that it was aware included:

- ❖ Home health agencies offering kickbacks to physicians, beneficiaries, hospitals, and rest homes in return for referrals, e.g.:
  - offering free services to beneficiaries, including transportation and meals, if they agree to switch home health agencies
  - providing hospitals with discharge planners, home care coordinators, or home care liaisons in order to induce referrals
  - providing free services, such as 24 hour nursing coverage, to retirement homes or adult congregate living facilities in return for home health referrals
  - subcontracting with retirement homes or adult congregate living facilities for the provision of home health services, to induce the facility to make referrals to the agency
  - targeting healthy beneficiaries on the street or in their homes and offering non-covered services, such as grocery shopping or housekeeping, in exchange for Medicare identification numbers
  - pressuring of physicians to order unnecessary personal care services by telling them that their patients were requesting the services and that they would refer those patients to other physicians unless they ordered them
- ➢ several of these actions could also be viewed as violations of the False Claims Act

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OIG Compliance Program Guidance Hospices

- Like home health agency guidance, hospice guidance discusses a number of risk areas potentially related to marketing, *e.g.*:
  - ➢ Arrangements with another health care provider who hospice knows is submitting claims for services already covered by the hospice benefit
    - *e.g.,* standard Medicare benefits for the treatment of terminal illness, treatment by another hospice not arranged for by patient's hospice, care by another provider that duplicates care that hospice is required to furnish
  - ➢ Hospice incentives to actual or potential referral sources (*e.g.* physicians, nursing homes, hospitals, patients, etc.) that may violate the anti-kickback statute or similar federal and state statutes or regs
    - *e.g.,* paying fee to physician for each terminal illness certification, or providing nursing, administrative, and other services to physicians, nursing homes, hospitals and other potential referral sources to influence referrals, or to an individual with expectation that it may influence person to use particular hospice

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OIG Compliance Program Guidance Hospices – Risk Areas (Cont'd)

- Overlap of services that a nursing home provides, resulting in insufficient care provided by a hospice to nursing home resident
  - specific issues of hospice/nursing home relationship discussed in separate slide(s)
- Improper relinquishment of core services and professional management responsibilities to nursing homes, volunteers, and privately paid professionals
- Providing hospice services in nursing home without a finalized written agreement
- High pressure marketing of hospice care to ineligible beneficiaries
  - should not offer free gifts or services to patients and marketing materials should clear, correct, non-deceptive and fully informative, *e.g.* don't create impression that terminal prognosis is of limited import, that benefits are provided over an indefinite period, and should prominently feature eligibility requirements for hospice benefit

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OIG Compliance Program Guidance Hospices – Risk Areas (Cont'd)

- Improper patient solicitation activities, such as "patient charting"
  - *e.g.,* review of patient records in an ALF without the patient's approval to "mine" resident population for hospice services
- Sales commission based on length of stay in hospice
  - may cause recruitment of long stay patients whose stays may be ineligible for hospice benefits
  - sales and marketing should also be monitored for other improper sales and marketing mechanisms by employees and contractors
- Compliance training should be "… relevant to hospice's marketing and financial personnel, in that the pressure to meet business goals may render these employees vulnerable to engaging in prohibited practices"
- Audits should focus on programs "… including external relationships with third party contractors…. At a minimum, these audits should be designed to address compliance with laws governing kickback arrangements … and marketing."
  - include assessments of existing relationships with physicians, nursing homes, hospitals and other potential referral sources

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OIG Compliance Guidance Hospices – Relationships with Nursing Homes

- Discussed separately in model compliance guidance documents for hospices and nursing facilities, as well as Special Fraud Alert issued in March 1998
- Special requirements covered in regulation at 42 C.F.R § 418.112, Condition of Participation: Hospices that provide hospice care to residents of a SNF/NF or ICF/IID
  - require *e.g.* written agreement to include division of labor and coordination of care
  - SNF/NF or ICF/IID provides room and board and services at the same level and to the same extent as if resident were in his/her own home with hospice having responsibility for all other services, and may provide other non-core services under contract with the hospice
  - For Medicaid patients in a nursing facility, hospice is paid a rate for room and board at 95% of the Medicaid nursing facility rate in the State and is responsible for paying the nursing home; non-Medicaid residents are required to pay room and board either privately or through insurance
  - Evidence of a coordinated care plan is present in the records of both providers
  - Hospice and nursing home's forms and documentation are kept separately

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OIG Compliance Guidance Hospices – Relationships with Nursing Homes – Questionable Practices

- Examples of questionable practices that have drawn scrutiny include:
  - a hospice offering free goods or goods at below fair market value to induce nursing facility to refer patients to the hospice
  - hospice paying rates for room and board to the nursing home in excess of rates that it would have received under Medicaid; additional payment must represent fmv of additional services provided to Medicaid patients that are not included under the Medicaid daily rate
  - hospice paying amounts to the nursing facility for additional services that Medicaid considers to be covered under the room and board payment to the hospice
  - hospice paying above fmv for services that Medicaid does not consider to be covered in the room and board rate paid to the hospice
  - hospice referring its patients to the nursing facility to induce the nursing facility to refer its patients to the hospice
  - hospice providing free or below fmv care to nursing facility patients, for whom the nursing facility is receiving Medicare payment under the SNF benefit, with the expectation that after the patient exhausts the SNF benefit, the patient will receive hospice services from that hospice

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OIG Compliance Guidance Hospices – Relationships with Nursing Homes – Questionable Practices (Cont'd)

- Examples of questionable practices that have drawn scrutiny, cont'd:
  - hospice providing staff at its expense to the nursing facility patients to the nursing facility
- Hospice should not review patient records in nursing facilities and ALFs for the purpose of recommending those patients who would ostensibly be appropriate for hospice referral without obtaining the patient's approval

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OIG Bulletin, Offering Gifts and Inducements to Beneficiaries

- Federal law prohibits offering a Medicare or Medicaid beneficiary any remuneration that the person knows or should know is likely to influence the beneficiary's selection of a particular provider, practitioner, or supplier of covered items or services
  - Penalty of up to $10,000 CMP for each wrongful act
  - Section 1128(A)(5) of the Social Security Act
- OIG Bulletin issued in August 2002 states that it "…provides bright-line guidance that will protect [Medicare and Medicaid], encourage compliance, and level the playing field."
- https://oig.hhs.gov/fraud/docs/alertsandbulletins/sabgiftsandinducements.pdf

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OIG Bulletin, Offering Gifts and Inducements to Beneficiaries – August 2002 (Cont'd)

- May offer inexpensive gifts (other than cash or cash equivalents) or services of nominal value. Per December 7, 2016, OIG Policy Statement, nominal value is now having retail value of no more than $15 per item or $75 in aggregate annually per patient. https://oig.hhs.gov/fraud/docs/alertsandbulletins/OIG-Policy-Statement-Gifts-of-Nominal-Value.pdf
- May offer more expensive gifts in 5 categories that include, among other things:
  - non-routine unadvertised waivers of cost-sharing based on individualized determinations of financial need
  - practices permitted under the safe harbor rules

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OIG Alert: Improper Arrangements and Conduct Involving Home Health Agencies and Physicians – June 22, 2016

- Discusses practices that OIG has found in investigations and studies of home health agencies. https://oig.hhs.gov/compliance/alerts/guidance/HHA_%20Alert2016.pdf
- Criminal convictions and settlements discussed included:
  - making and accepting payment for patient referrals
  - falsely certifying patients as homebound
  - billing for medically unnecessary services or for services not rendered
  - arrangements involved home health agencies, individual physicians, and heads of home-visiting physician companies

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OIG Alert: Improper Arrangements and Conduct Involving Home Health Agencies and Physicians (cont'd)

- Criminal convictions and settlements discussed (cont'd):
  - payments for referring or soliciting Medicare and Medicaid patients sometimes involved payments to physicians disguised as payments for serving as medical director
  - HHAs billing for medically unnecessary nursing services to patients not confined to home
  - home-billing physician companies upcoding patient visits and billing for care plan oversight services not actually rendered
  - physicians falsely certifying patients as homebound

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OIG Fraud Alert: Physician Compensation Arrangements May Result in Significant Liability – June 9, 2015

- Discusses settlement reached by OIG with 12 individual physicians https://oig.hhs.gov/compliance/alerts/guidance/Fraud_Alert_Physician_Compensation_06092015.pdf
- Compensation relationships discussed included:
  - Payments taking into account value and volume of referrals and did not reflect fair market value for services performed
  - Non-performance by physicians of services called for under the agreement
  - Payment of salaries of physician office staff

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Other guidance – OIG Advisory Opinions

- Healthcare providers can request the OIG issue an Advisory Opinion on whether a particular relationship, arrangement or transaction violates the AKS
- Requestors submit documentation to OIG describing and documenting the arrangement, and attesting information provided is true, correct and complete
- OIG will issue an opinion that, if favorable, effectively immunizes that arrangement from further scrutiny
- Example, Advisory Opinion 15-12 – Home health agency offered free introductory visit to patients who had selected the agency. This visit is not a covered or reimbursed service. The agency is chosen from a list of HHAs provided by a physician or hospital. Patient is contacted and offered the introductory visit, identifying and showing pictures of care team and discussing care transition. OIG found the practice did not violate the AKS as visits do not constitute improper remuneration to beneficiaries. https://oig.hhs.gov/fraud/docs/advisoryopinions/2015/advopn15-12.pdf

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OIG Work Plan- Open Audits Relating to Home Health or Hospice

- Home Health Agencies' Challenges and Strategies in Responding to the COVID-19 Pandemic
- Audit of Home Health Services Provided as Telehealth During the COVID-19 Public Health Emergency
- Use of Medicare Telehealth Services During the COVID-19 Pandemic
- Infection Control at Home Health Agencies During the COVID-19 Pandemic
- Audit of CARES Act Provider Relief Funds: General and Targeted Distributions to Providers
- Audit of CMS's Controls Over the Expanded Accelerated and Advance Payment Program Payments and Recovery
- Results of UPICs' Benefit Integrity Activities
- Review of Hospice Inpatient and Aggregate Cap Calculations
- Home Health Compliance with Medicare Requirements
- Duplicate Payments for Home Health Services Covered Under Medicare and Medicaid
- Medicare Payments Made Outside of the Hospice Benefit
- Medicaid Health Home Services for Beneficiaries with Chronic Conditions
- Hospice Home Care - Frequency of Nurse On-Site Visits to Assess Quality of Care and Services
- Review of Hospices' Compliance with Medicare Requirements
- Medicare Payments for Chronic Care Management
- Home Health Agencies' Emergency Communication Plans: Strengths and Challenges Ensuring Continuity of Care During Disasters

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Texas laws

- Texas Patient Solicitation Act (Tex. Occupations Code § 102.001 *et seq.*) – analogous to Anti-kickback statute and permits any arrangement or practice permitted by federal AKS
- Texas Physician Solicitation prohibition (Tex. Occupations Code §165.155 – analogous to Stark law
- Texas Medicaid Fraud Prevention Act (Tex. Human Resources Code § 36.001 *et seq.)* – analogous to federal False Claims Act
- Texas Commercial Bribery (Texas Penal Code § 32.43) – no federal equivalent. There are no safe harbors. Fiduciary commits offense if, without consent of beneficiary, solicits, accepts, offers or confers or agrees to accept or confer benefit that will influence conduct of fiduciary in relation to beneficiary. Physician is a "fiduciary" under law. Violation = felony.

➢ *Why is this important? New tactic – Federal government is now using Travel Act (18 USC § 1952) to enforce state laws. See Forest Park case – kickbacks paid to induce referrals to physician-owned hospital for out-of-network services violate Texas law and because involved use of mail, Internet, computer networks, etc., violate Travel Act.*

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Texas Guidelines on Marketing

- Texas HHSC issued guidelines for marketing for providers enrolled in Texas Medicaid, CHIP programs
- Prohibitions:
  - Unsolicited personal contacts such as email or telephone
  - Offering inducements or give-aways of more than $10 value
  - Offering gifts or inducements designed to influence individual's choice of provider
  - Reading level greater than 6th grade
- Guidelines contain recommended checklist for provider review of marketing materials
- Provider may submit marketing materials to HHSC for review and approval. Decision generally issued within 30 days.
- https://www.hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/provider-information/texas-provider-marketing-guidelines.pdf

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Examples of problematic practices

- Sham medical directorships – physician is paid to serve as medical director in exchange for patient referrals
- Agreements with nursing homes to send patients to the hospice
- Marketing materials and agreements that fail to discuss "terminal illness" requirement for Medicare hospice coverage
- Free or below market value services provided by hospice to nursing home
- Referring a home health or hospice patient to a nursing home in exchange for nursing home referring hospice patients
- Multiple medical directors with compensation based on number of referrals

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Examples of problematic practices – (cont'd)

- Payments to patient recruiters that are based on volume or value of referrals
- Excessive payment for space rentals to ALFs
- Payments by staff of HHA or home care agency to patients or sham patients to bill for services never rendered or for patients/clients who would not be eligible for services based on condition
- Payment to patients who were not homebound to use Medicare number to bill for services never rendered or not covered
- HHA going through medical records of SNF or ALF patients to mine for referrals without specific patient permission

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Case study – 2020 National Healthcare Fraud Takedown, September 30, 2020

- 345 defendants in 51 judicial districts
- More than $6 billion in alleged losses to federal health care programs
- "Telefraud"
- Opioid prescribing
- DME owner and the manager of a DME company were charged in connection with a scheme that used a telemarketing operation to collect the personal information of Medicare beneficiaries, purchased doctor's orders for orthotic braces for the beneficiaries under the guise of "telemedicine"
- A marketing company that allegedly recruited Medicare beneficiaries for medically unnecessary genetic testing that was ordered by telemedicine physicians in exchange for the payment of illegal kickbacks and bribes to telemedicine companies
- Paying and receiving illegal kickbacks for home health services, Western District of Texas

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Case study – 2021 National Healthcare Fraud Takedown, September 17, 2021

- 138 defendants in 31 judicial districts
- 42 doctors, nurses, and other licensed medical professionals
- More than $1.4 billion in alleged losses to federal health care programs
- $1.1 billion in losses related to telemedicine
- COVID-19 fraud
- Sober homes
- Opioid prescribing
- Western District of Texas - 2 defendants were charged with conspiracy to commit health care fraud and 14 counts of health care fraud. Defendants enrolled elderly individuals in hospice care who had no terminal diagnosis and did not need hospice care. To facilitate the scheme, the defendants created false medical records, forged the signatures of medical personnel, and fraudulently billed Medicare. It is estimated that the defendants overbilled Medicare in excess of $4 million. Another defendant was also charged with paying illegal remunerations regarding a federal health care program, directing payment of referral fees to several recipients for referrals of hospice patients to her company that did not qualify for hospice care.

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Case study – US v. VITAS Hospice Services (Missouri, 2017)

- VITAS is largest hospice chain in country
- Allegations include that VITAS engaged in marketing campaigns to families that misrepresented the purpose of hospice, promoting "intensive comfort care" as covered even if patient did not have acute symptoms
- VITAS trained marketers on how to "sell hospice" and paid employees bonuses based on number of patients enrolled in program and for patients with longer stays and need for continuous home care services, setting goals for # of crisis care days to be billed. Marketers who did not meet monthly admission goals were disciplined
- VITAS failed to train medical directors on hospice eligibility criteria. One physician said VITAS expected him to certify patients without actually making a determination that patient has 6 months to live. Another physician refused to certify certain patients but was overruled by the medical director. Likewise, another physician was overruled when he attempted to discharge patients
- Several VITAS medical directors conducted their own internal review of San Antonio location and discharged 75-80 patients for failure to meet eligibility criteria. No further action was taken.

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Case Study – US v. VITAS Hospice Services (Missouri, 2017) (*cont'd*)

- One physician informed the VP of Operations that the medical director for the San Antonio location had knowingly admitted and certified ineligible patients. Nothing further was done
- Field nurses who were providing care to NH residents were expected to identify patients and encourage referrals
- Hospice program was also marketed to assisted living facilities as service for individuals who might actually get better
- Audits and reviews demonstrated patients did not meet criteria for crisis care, and comparison to NHPCO benchmark data revealed VITAS billed for twice as many crisis care days as all other hospice providers combined
- VITAS paid $75 million to government plus relators' fees and expenses (total payout approx. $85 million) and signed 5 year Corporate Integrity Agreement

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Case Study – US v. Jacques Roy (Texas, 2017) and related HHA owners

- Dr. Jacques Roy had 11,000+ patients and was affiliated with 500 HHAs
- The HHAs would refer patients to Roy, who would then "refer" them back to the HHA. He had referral agreements with multiple home health agencies
- Home health agency personnel drove around Dallas homeless shelter, offering food stamps or to buy groceries. One HHA owner paid recruiters $50 and offer to buy homeless patients McDonalds. Other HHAs went door to door looking for Medicare beneficiaries.
- Some HHAs had 80% of their patients "referred" by Dr. Roy
- His office handled more home health visits than any other physician's office in the country. With this volume, he had employees fraudulently sign his name to POCs and certifications
- Government used data analytics to identify the fraud
- OIG said that most physicians refer fewer than 100 patients for home health
- When Dr. Roy's first practice was suspended, he created a second practice which paid significant "management fees" to the original practice
- Roy sentenced to 35 years, others from 3 to 17.5 years. Roy to pay $268 million in restitution

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Case Study – US ex rel Cordingley v. Good Shepherd Hospice (Missouri, 2015)

- Good Shepherd was based in Oklahoma City, providing services in Oklahoma, Texas, Missouri, and Kansas through 15 offices; Whistleblower was executive director of one of the offices for 6 months
- Hospice hired medical directors based on ability to refer patients, focusing on medical directors with ties to nursing homes. Hospice had 4-5 medical directors, who each worked 2 hours per month, and received about $3,000 salary monthly
- Hospice required medical directors to refer one patient per month. One medical director was terminated for failing to bring in referrals; he subsequently expressed concern about the quality of care as reason for not referring patients
- Hospice would keep at least 1 patient in a nursing home as hospice patient, so that they would have access to NH to continue to market hospice services

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Case Study – US ex rel Cordingley v. Good Shepherd Hospice (Missouri, 2015) (*cont'd*)

- Hospice nurses also performed work of NH nurses when in facility treating the hospice patients. "If you give me five patients, I'll put a nurse's aide in your building all day long." Also provided expensive Broda chairs free of charge
- Hospice also paid for residents' room and board, even if it did not receive Medicare payment due to faulty paperwork
- "Hospice Consultants" (aka marketers) gave NH staff gift baskets and free lunches, to achieve quota of 5 admissions per month.
- Good Shepherd settled for $4 million and 5 year Corporate Integrity Agreement

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Case Study – Serenity Marketing, Inc. (Illinois, 2016)

- Sundae Williams owned a telemarketing company. She and her employees made unsolicited cold-call phone calls to recruit patients, including Medicare and Medicaid beneficiaries, for home health services. The patients were then referred to a number of Chicago-area HHAs.
- The HHA owners paid her for "marketing services". The HHA owners entered into contracts that said the services were paid for on an hourly rate. However, Serenity Marketing never tracked hours actually worked and billed the HHAs by converting each patient referral into a made-up number of 10 hours worked. Ms. Williams usually received $600 per patient.
- Ms. Williams was convicted at trial and sentenced to a year in federal prison and $599,000 forfeiture, representing her revenues from her scheme.
- In addition, the HHA owner, James Ademiju, RN, a physician who signed the referrals, Alan Newman, MD, and an RN working with the physician, Diana Gumila, were also convicted. Ademiju received a 11 month sentence plus $1.5 million restitution, Dr. Newman a 1 year sentence plus $2.6 million restitution, and Gumila a 6 year sentence plus $15.6 million restitution.

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Case study – US v. Mercy Ainabe (Texas, 2018)

- Ms. Ainabe functioned as a patient recruiter for Texas Tender Care, which she owned. She tried to make it look like she was an employee for other home health agencies, being paid a legitimate hourly wage as a marketing representative, but in fact she was being paid for patient referrals.
- Ms. Ainabe was also a "shadow owner", meaning she received a portion of the Medicare payments after other conspirators were paid for their roles, but she was not listed as an owner of the company in state corporate filings or on other documents.
- In turn, Ms. Ainabe paid doctors kickbacks to authorize the services. She also paid physical therapists and others to complete paperwork.
- After conviction in a jury trial, she was sentenced to 9 years prison.

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Case Study – US ex rel. Herbold v. Doctor's Choice Home Care, Inc., (Florida, 2019)

- Doctor's Choice Home Care, Inc., (DCHC) a Sarasota, Florida home health agency paid kickbacks to 3 referring physicians in the form of sham medical directorships. The physicians did little or no work. If physicians did not make sufficient referrals, the medical directorships were terminated early. DCHC closely tracked payments to physicians and compared them to referrals to DCHC.
- In addition, DCHC hired the spouses of physicians as employees. The spouses were paid in a manner that accounted for the volume of referrals by their physician spouses.
- Evidence shows employees were given compliance training, including a 2004 presentation discussing compliance issues with medical directors.
- Owner Christensen sent emails to account execs saying "When I see dinners I will expect some business"; "Dr. [G] is not working out as a med director… He has only given us 17 ref in 6 mo…I think we could find someone more productive with his spot. We've paid him 6K so far"; "[G] [gets an] F this month"; "Med Directors are not doing good. My suggestion is to have a talk with them and let them know what the expectation is."

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Case Study – US ex rel. Herbold v. Doctor's Choice Home Care, Inc., (Florida, 2019) (*cont'd*)

- Relator was an account executives (marketing). She also raised concerns that Dr. S. was not performing the services identified on his invoices.

➢ After relator joined a competitor, DCHC emailed Dr. S. to prevent him from following her to a competitor. "If you are not going to give [us] 50% of the business, we will be forced to do the following:

  - Personally meet with each and every Family/General/Internal Medicine Physician …to explain your financial relationship with [relator]
  - Notify all State and Federal Agencies of [relator's] illegal activities (medical director invoices, marketing expenses to physicians and their significant others and most importantly signing physician orders) … Let me know your intentions or we will assume you will be giving [competitor] 100% of your business."

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Case Study – US ex rel. Herbold v. Doctor's Choice Home Care, Inc., (Florida, 2019) (*cont'd*)

- DCHC allegedly arranged for and paid for the costs of Dr. S. to give lectures to the public to market himself and his practice. Dr. S. then invoiced DCHC's sister entity for the time spent giving the lectures.
- Dr. S. also allegedly performed chart reviews, but none of the Chart Review forms reflected meaningful work and most were signed without comment.
- Dr. S. was paid for 7 hours of time learning to use DCHC's online portal for patients and 8 hours on a handbook to be distributed to his patients.
- Compliance person raised concerns about lack of documentation and also said she did not remember a 3 hour in-service that Dr. S. submitted an invoice for.

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Case Study – US ex rel. Herbold v. Doctor's Choice Home Care, Inc., (Florida, 2019) (*cont'd*)

- Dr. J signed medical directorship agreement and received his first payment of $4k before doing any work, along with patient charts. Within 1 hour, Dr. J. returned the signed charts and an invoice for 9 hours of review. When account exec challenged him with impossibility of doing 9 hours of work in the space of 1 hour, he insisted he had done the work. Account exec went to CEO, who told her to "leave things alone" and just keep on getting referrals. DCHC then hired Dr. J's girlfriend (and later wife), offering a "very lucrative" compensation plan.
- Dr. F, an interventional pain physician, was contracted a "consultant" to perform in-service trainings. Staff were sent to Dr. F's office to watch him perform routine procedures which provided little educational value. Dr. F later became a medical director and submitted invoices charging 1 hour time for each chart reviewed. Chart Review forms were also signed with no comment. The account execs dropped off charts for review often waiting while he signed the Chart Review forms. Dr. F was informed by DCHC personnel that it didn't matter how much time he actually spent on chart reviews.

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Case study – US v. Dubor and Whitaker (Texas, 2018)

- John Dubor, RN, owned Care Committers Health Services, Inc. Dubor and Whitaker paid group home owners for access to and for referring Medicare beneficiaries, up to $500 for an initial certification and $250 for a recertification. Payments were made both in cash and by check.
- Dubor paid marketers and recruiters, including Whitaker, to find beneficiaries. Beneficiaries were paid to sign blank home health forms.
- Dubor was found guilty after 4 day jury trial and sentenced to 9 years prison and $3.5 million restitution.

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Overview of Cloud Based Social Media Use by Health Care Providers

- Many health care provider organizations have incorporated cloud-based social media into their patient education programs, the primary purpose of participating in social media remains ***marketing***.
- Many health care providers have found that the effective use of cloud-based social media can generate both business and public interest in the provider's services which goes far beyond that obtained through the use of a mere static website.
- As a result, a significant number of health care providers now actively inform and engage patients and clients through the use of this medium.

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Overview of Cloud Based Social Media Use by Health Care Providers

- Inappropriate conduct online can begin early in a medical professional's career. It is therefore essential that you reinforce the need for professionalism in your office.
- Surprisingly, ***60% of U.S. medical schools reported incidents of students posting unprofessional content online***. Of the medical schools which participated in the survey, specific violations included:
  - 13% committed patient privacy violations.
  - 52% used profanity.
  - 48% posted discriminatory comments.
  - 39% posted depictions of intoxication.
  - 38% posted sexually suggestive materials.

(Source: JAMA, Sep. 2009).

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Overview of Cloud Based Social Media Use by Health Care Providers

- **Despite their popularity, health care providers and billers have been quick to point out a wide variety of concerns regarding the use of this medium. Broad patient related concerns include:**
  - **Issue #1: Potential *patient privacy violations*.**
  - **Issue #2: *Many providers believe that posting on social media is a waste of time which could be better spent taking care of patients*. Essentially, the return on investigate from engaging in social media is difficult to gauge.**
  - **Issue #3: *The potential posting of incorrect or misleading content by others*. Many providers and billers allow individuals to make a post on their Linked-In and / or Facebook pages. Comments made by outsiders may be unprofessional, critical of the provider's care and / or include links to questionable websites.**
  - **Issue #4: Patient comments and / or postings may create *an unreasonable expectation that a health care provider will soon respond to a posting*.**
  - **Issue #5: *Postings by health care providers are often quite short,* despite the fact that the medical issues discussed can be quite complicated. This can lead to potential liability from readers who misread or misapply the information provided.**

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American Nursing Association Ethics

- Principles for Social Networking and the Nurse: Guidance for the Registered Nurse, https://www.nursingworld.org/~4af4f2/globalassets/docs/ana/ethics/social-networking.pdf:
  - Nurses must not transmit or place online individually identifiable patient information.
  - Nurses must observe ethically prescribed professional patient-nurse boundaries.
  - Nurses should understand that patients, colleagues, institutions and employers may view postings.
  - Nurses should take advantage of privacy settings and seek to separate personal and professional information online.
  - Nurses should bring content that could harm a patient's privacy, rights or welfare to the attention of appropriate authorities.
  - Nurses should participate in developing institutional policies governing online contact.

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Acceptable Marketing Activities

- Focus on what differentiates your agency
  - Star ratings?
  - Use of technology?
  - Specialized services?
- Blogging is OK
- Don't allow comments on website or Facebook
  - Don't respond to posts/comments
- Beware of incentives to beneficiaries

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Acceptable Marketing Activities

- In person activities
  - Lunch and learns are OK
  - Modest meals/lunches are acceptable, provided they are infrequent
    - ❖ There should NOT be an expectation from the recipients that they will routinely receive food
  - Only those people who have a need to hear the presentation or material
- Holiday gifts can be acceptable
  - Nominal value
  - Share-able by all in the office – box of chocolates, fruit tray, etc.

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Tips and Best Practices

- Understand the AKS and Stark laws
- Ensure that every relationship with a physician is documented
- Ensure that every contract or arrangement with a physician is reviewed by a healthcare attorney
- Document valid business rationale and fair market value of services, items
- If it sounds too good to be true, it probably is
- Ensure that your employees are truly employees

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Tips and Best Practices

- Medical directors should be compensated solely for clinical services. There should be no link to referrals or admissions.
- Document time and effort to support medical director services
- Train medical directors on eligibility criteria, Medicare care definitions, and compliance with law
- Monitor relationships with outside referring physicians, their offices, and marketers as part of your compliance program
- Review invoices submitted to ensure that services provided and hours worked are reasonable for particular category of services

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Tips and Best Practices

- Carefully evaluate compensation plans for employees
  - ✓ Compensation should not be based on number of admissions or lengths of stay.
  - ✓ Even though there is bona fide employment safe harbor/exception, note that many of the cases involving employees still were problematic. Remember "one purpose" rule.
  - ✓ Incentive payments, if any, should not be based on individual economic production.
- Compensation for marketing by independent contractors should meet the personal services safe harbor.
  - ✓ Should be at fair market value and not based on volume or value of referrals.
  - ✓ Contracted services should be valid services and not a "cover" for referrals.

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Tips and Best Practices

- Separate the marketing function from the intake/admissions function
- Intake/admissions personnel should not receive bonuses based on new patients admitted
- Stay away from quotas for admissions, and don't fire people for failure to meet "goals"
- Beware of excessive focus on numbers and revenue
- Routinely check your referral patterns. Unless you are in a rural or underserved area, you should not have more than about 20% of your referrals coming from any one physician.
- Train marketers and admissions / recertification personnel on eligibility criteria, Medicare definitions and compliance with the law
- Monitor marketing practices of independent contractors as well as employees, and their relationships with referral sources

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Tips and Best Practices

- Carefully evaluate your marketing materials and approach to patients
- Ensure patients and family members understand purpose of home health and hospice
- Avoid giving gifts, freebies to patients or family members. If you must give gifts, in Texas, stay under value of $10 per gift and $50 total per patient per year (federal policy allows $15 per gift and $75 per year)
- Use checklist in Texas Provider Marketing Guidelines
- Avoid offering free or discounted services to other health care providers or facilities in connection with home health or hospice patients
  - Especially important in hospice relationships with nursing facilities

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Tips and Best Practices

IF IN DOUBT, ASK!

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Questions?

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