4a. Fraud, Waste and Abuse

Presented by:

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Fraud, Waste and Abuse Laws
Recent Developments & Compliance Tips

Texas Association for Home Care and Hospice (TAHC&H)

Tuesday, November 15, 2022

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- Overview: Health care spending has come under increased scrutiny, which has spurred increased regulatory enforcement efforts by both federal and state health care program officials.

- Statutory Requirements are Complex and Subject to Change. Non-compliance can result in criminal charges, civil sanctions, and/or civil monetary penalties. Moreover, failure to comply with applicable health care laws and regulations could expose an agency, its leadership and its owners to extensive civil liability.

Background
Welcome to the 30 Year Lookback at Federal Criminal Prosecutions of American Companies

**Since fiscal year 1992:**

- Most of the organizational offenders (companies) that were criminally prosecuted, and subsequently sentenced by Federal Courts, have been domestic (88.1%), private (92.2%), and small – with less that 50 employees (78.4%).
- An overwhelming majority of organizational offenders (89.6%) did not have a compliance and ethics program.
- Only 11 of the almost 5,000 organizations criminally prosecuted received a sentencing "reduction" under the U.S. Sentencing Guidelines for having an effective compliance and ethics program.
- Only 1.5% received a sentencing reduction for disclosing an offense prior to a government investigation, in addition to fully cooperating and accepting responsibility.
- While criminal prosecutions of companies have declined, DOJ’s focus on individuals involved in criminal conduct has increased.

Welcome to the Current Enforcement Environment

**September 15, 2022.** Deputy Attorney General (DAG) Lisa Monaco issued an update to her previous guidance issued on October 28, 2021. In this guidance, she again reiterated that:

“The Department’s first priority in corporate criminal matters is to hold accountable the individuals who commit and profit from corporate crime... Corporations can best deter misconduct if they make clear that all individuals who engage in or contribute to criminal misconduct will be held personally accountable. In assessing a compliance program, prosecutors should consider whether the corporation’s compensation agreements, arrangements, and packages (the "compensation systems") incorporate elements such as compensation clawback provisions that enable penalties to be levied against current or former employees, executives, or directors whose direct supervisory actions or omissions contributed to criminal conduct.”

You cannot expect to avoid personal liability by hiding behind your organization’s settlement with DOJ and / or the OIG.
Current Trends

- Criminal prosecutions for health care fraud related to home health have been very active in Texas – legacy of Roy Jacques, MD
- Integrity auditors are still very active – seeing more suspensions and revocations along with overpayment demands

Current Federal Investigation and Enforcement Efforts - General Overview

- Strike Force teams currently operate in nine areas -- Miami, Florida; Los Angeles, California; Detroit, Michigan; South Texas (including Houston & McAllen); Brooklyn, New York; Southern Louisiana; Tampa, Florida; Chicago, Illinois; Newark, New Jersey; Philadelphia, Pennsylvania; and Dallas, Texas. A corporate strike force also operates out of Washington, D.C.
Current Enforcement Environment

- **Enforcement efforts remain high post-COVID.** Settlements and judgments from civil cases involving fraud and false claims against the government set a five-year high in 2021. Of the more than $5.6 billion recovered during 2021, more than $5 billion is attributable to health care related cases and matters.

<table>
<thead>
<tr>
<th>Year</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
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<tbody>
<tr>
<td>Civil Fraud Recoveries</td>
<td>$3.4 billion</td>
<td>$2.8 billion</td>
<td>$3.1 billion</td>
<td>$2.2 billion</td>
<td>$5.6 billion</td>
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- Notably, $1.6 billion of these recoveries were associated with the 589 whistleblower cases.
- During FY 2021, DOJ opened 805 new civil health care fraud investigations.
- During this period, DOJ opened 831 new criminal health care fraud investigations. DOJ prosecutors filed criminal charges in 462 cases involving 741 defendants.
- During FY 2021, HHS-OIG excluded 1,689 individuals and entities from participation in Federal and health care programs.

**Whistleblower lawsuits** continue to be the most significant source of civil investigation for DOJ (data for FY2021):

- 598 qui tam (whistleblower) cases filed; 388 of these were healthcare related
- DOJ recovered $1.6+ billion total, with $1.4+ billion arising from healthcare related settlements
- $197 million was awarded to healthcare whistleblowers.
- Since 1987, the federal government has recovered $48 billion from health care fraud cases brought under the civil False Claims Act (both whistleblower and non-whistleblower cases).

We are seeing more and more non-whistleblower cases!

- DOJ reported 122 new civil matters in 2020, and 97 in 2021, with $400M recovered in 2020 and $3.5+B recovered in 2021.
Combined Recovery By DOJ/HHS

Monetary Results: Total Transfers/Deposits by Recipient FY 2021

<table>
<thead>
<tr>
<th>Department of the Treasury</th>
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<tbody>
<tr>
<td>Deposits to the Medicare Trust Fund, as required by HIPAA:</td>
</tr>
<tr>
<td>Gifts and Bequests $176</td>
</tr>
<tr>
<td>Amount Equal to Criminal Fines 67,452,798</td>
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<tr>
<td>Civil Monetary Penalties 69,317,338</td>
</tr>
<tr>
<td>Asset Forfeitures 134,792,877</td>
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<tr>
<td>Penalties and Multiple Damages 385,310,905</td>
</tr>
<tr>
<td>Subtotal $656,863,753</td>
</tr>
<tr>
<td>Centers for Medicare &amp; Medicaid Services</td>
</tr>
<tr>
<td>HHS/OIG Audit Disallowance: Recovered Medicare 46,984,919</td>
</tr>
<tr>
<td>Restitution/Compensatory Damages* 462,322,346</td>
</tr>
<tr>
<td>Subtotal $551,116,666</td>
</tr>
<tr>
<td>Total Transferred to the Medicare Trust Funds $1,307,980,409</td>
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</table>

Restritution/Compensatory Damages to Federal Agencies

| TRICARE $39,348,018 |
| HHS-OIG 10,345,715 |
| Office of Personnel Management 9,638,816 |
| U.S. Postal Service 1,318,076 |
| DOJ/Drug Enforcement Administration 875,816 |
| Other Agencies 1,731,100 |
| Subtotal $63,457,299 |
| Centers for Medicare & Medicaid Services |
| Federal Share of Medicaid 98,664,671 |
| HHS/OIG Audit Disallowance: Recovered Medicaid 295,874,235 |
| Subtotal $394,538,906 |
| Total $457,996,203 |

Recovery Payments** $1,895,022,418

*Restriction, compensatory damages, and recouped audit disallowances include returns to both the Medicare Hospital Insurance (Part A) Trust Fund and the Supplemental Medical Insurance (Part B) Trust Fund.
**These are funds awarded to private persons who file suits on behalf of the Federal Government under the qui tam (whistleblower) provisions of the False Claims Act, 31 U.S.C. § 3730(b).
***State funds are be collected on behalf of state Medicaid programs, only the federal share of Medicaid funds transferred to CMS are represented here.


- 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 shelters, offering food stamps or to buy groceries. One HHA owner paid recruiters $50 and offered 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.
- Charged with obstruction of justice!
- Roy sentenced to 35 years, others from 3 to 17.5 years. Roy to pay $268 million in restitution

In November 2019, a jury convicted Mesquias, McInnis and Pena with Merida Hospice for their roles in a $154 million health care fraud scheme. Convictions included conspiracy to commit healthcare fraud/money laundering/obstruction of justice, healthcare fraud, obstruction of health care investigations, and making false statements.

- From 2009-2018, the owner, Administrator and medical director enrolled patients in hospice by falsely telling them that they had less than six months to live and sent chaplains to lie to the patients and discuss last rites and preparation for their imminent death. Patients were offered free items they would otherwise have to buy to entice them to agree to admission.
- Patients were kept on service for multiple years and employees who refused to go along with the fraud were fired.
- Medical Director (who was also a mayor) gave false statements to the FBI and directed others to lie to the FBI to cover up his involvement.
- Owner and CEO created false records and produced them to the grand jury to try and avoid indictment.
- Defendants placed companies in name of sham owners to hide kickback payments to physician referral source.
- Defendants bribed physicians for referrals with lavish parties at Las Vegas clubs, trips, sports tickets, access to luxury cars and properties.

- Owner sentenced to 20 years and $120M in restitution, and CEO sentenced to 15 years. Medical Director died of COVID-19 before sentencing.

US attorney for SDTX has unsealed a whistleblower case involving these defendants that was filed in 2015! The case was filed by former employees of Merida.
Texas Home Health & Hospice Prosecutions – 2019-2022 Examples

- In April 2022, the owners of Colony Home Health Services and Milton Medical Clinic were convicted at trial of conspiracy to commit and committing health care fraud. The jury deliberated for 45 minutes! The HHA owner paid recruiters to bring patient information to be billed for home health services regardless of whether they needed it or not. Beneficiaries testified and admitted they did not need home health services at the time the health care service providers billed them. Additional testimony revealed a physician at the medical clinic had signed off on plan of care forms when patients were not actually under his care. Both defendants were sentenced to 10 years. Employees who plead guilty sentenced to 2.5 and 5 years.

- Husband and wife owners of Guaranty Home Health plead guilty to conspiracy to commit healthcare fraud, and their co-conspirator who was their office manager chose not to plead and was convicted by a jury on 10 counts of conspiracy and committing healthcare fraud. Facts included billing for services that weren’t needed or never provided, and billing for services provided to deceased or incarcerated individuals. The office manager claimed she was not aware of the fraudulent activities, but the government showed that she created and submitted claims to Medicare, was the signor on at least one HHA bank account and used company funds to pay for her side-business and to purchase a luxury car. Owners received 2.5 and 6 years in prison and were ordered to pay $21M+ in restitution. Office Manager was sentenced to 12 years in prison and $21M+ in restitution.

Texas Home Health & Hospice Prosecutions – 2019-2022 Examples

- Owner of Friend’s Place and Metro Health Services, both HHA’s, plead guilty to committing and conspiracy to commit healthcare fraud. From May 2006 to June 2019, Naomi Moore billed Medicare by fraudulently using names of beneficiaries that were not patients of Metro or Friend’s Place. They did not need home health services, were not treated by a physician and had never been patients. Moore created false documents and billed Medicare for approximately $10.7 million in purported home health services. Medicare paid nearly $6.8 million on those claims. Defendant was sentenced to 5 years and ordered to pay restitution.

- Novus Hospice – Thirteen defendants involved in the $27 million Novus healthcare fraud have now been sentenced to a combined 84 years in federal prison. The conspirators defrauded Medicare by submitting materially false claims for hospice services, providing kickbacks for referrals, and violating HIPAA to recruit beneficiaries. Novus employees also dispensed Schedule II controlled substances to patients without the guidance of medical professionals and moved patients to a new hospice company in order to avoid a Medicare suspension. CEO Bradley J. Harris eventually admitted to the fraud and testified against two physicians who elected to proceed to trial. Two doctors and a hospice nurse were convicted at trial and sentenced to 13 years, 10 years and 33 months. Ten others plead guilty and have been sentenced including the CEO (13.25 years), the VP of Marketing (33 months) and the Director of Marketing (4 years), the VP of Patient Services (the CEO’s wife...3.25 years), four hospice nurses including the VP of Operations (7 years, 8.5 years, 5.5 years, and 8 years), Medical Director (4.75 years) and the owner of a medical group (1.5 months).
Texas Home Health & Hospice Prosecutions – 2019-2022 Examples

- Onder Ari and Sedat Necipoglu, owners of Allstate Hospice LLC and Verge Home Care LLC Ari allegedly: offered compensation to physicians who were responsible for a significant majority of their patient referrals by paying monthly medical directorship fees that were in excess of fair market value for the services the physicians actually provided; sold interests in Allstate to five different physicians that paid the physicians substantial quarterly dividends; and, provided physicians other gifts and benefits, such as travel and tickets to sporting events, all in violation of the Stark Law and the Federal Anti-Kickback Statute. In January 2019, the defendants and government agreed to settle the case for $1.8M+.

Texas HHSC State OIG – Settlements

- Texas HHSC OIG continues to investigate fraud, waste and abuse by Medicaid providers.
  - In June 2022, the OIG settled a case involving a Plano pediatric home health care provider who incorrectly billed Medicaid for some services and lacked doctors’ authorizations to support some submitted claims. The provider agreed to pay $54,014 in overpayment and $143,029 in penalties to resolve this case.
  - The OIG settled cases in June 2022 with four home health providers in Hidalgo County. A personal care attendant working for all four providers double-billed each home health agency for services provided to separate clients who lived in the same residence. The settlement led to the attendant being excluded from working for any Medicaid provider for the next 10 years. Additionally, the four providers agreed to pay a $30,840 settlement to the state.
  - In March 2022, the OIG settled a case with a Houston home health agency that offers PDN services. From January 2015 to June 2021, the home health agency billed Medicaid for PDN using a modifier reserved for patients who have a tracheostomy or are ventilator-dependent, when the patients did not have a tracheostomy and were not ventilator-dependent, which resulted in an upcode. The provider agreed to pay $400,000 to resolve the case.
What’s Fraud, Waste, and Abuse?

Fraud is conduct that involves intentional deception or misrepresentation, knowingly making a false claim, or other intentional or willful deception or misrepresentation, known to be false or otherwise unlawful or improper, in order to receive some unauthorized benefit.

“Knowing” can mean actual knowledge or acting with reckless disregard or deliberate ignorance of truth or falsity.
Waste

Waste involves practices that are inconsistent with sound fiscal, business, or medical practices, and that result in an unnecessary cost to Medicare, Medicaid or other programs.

Abuse

Abuse is deception or misrepresentation that a company or person should know to be false, knowing or improper, and should know will result in some unauthorized benefit to the company or person.
What Laws Apply to Fraud, Waste, and Abuse?

Federal Civil Laws

- Used to address harm, loss, or injury
- Generally impose a monetary or other penalty, but no jail
- Can be very black and white – you are or you aren’t
- Investigations may be initiated by a private party or the government
- No need to prove wrongful intent
- Burden of proof on the plaintiff
- Burden of proof is “preponderance of the evidence”

Many of the Fraud Section’s cases are suits filed under the False Claims Act (FCA), 31 U.S.C. §§ 3729 - 3733, a federal statute originally enacted in 1863 in response to defense contractor fraud during the American Civil War.
Federal Criminal Laws

- Punishment of criminal offenses
- Permit imposition of jail time
- May also be coupled with monetary fine
- Always initiated by government
- Government has to prove wrongful intent
- Burden of proof is on the government
- Burden of proof is “beyond a reasonable doubt”

Federal Criminal Laws

- 18 U.S.C. § 1343 (Wire Fraud)
- 18 U.S.C. § 1347 (Health Care Fraud)
- 18 U.S.C. § 1349 and 18 U.S.C. § 371 (Attempt or conspiracy to commit health care fraud, and conspiracy to defraud the United States)
- 18 U.S.C. §§ 1957 (Money Laundering)
- 18 U.S.C. §§ 1956 (Money Laundering)
- 42 U.S.C. § 1320a-7(b) (Health Care Kickbacks)
- 18 U.S.C. §§ 1518, 1519 (Obstruction)
- 18 U.S.C. § 669 (Theft or Embezzlement in Connection with Health Care)
- 42 U.S.C. § 1320d-6 (Unlawful Use of Health Information)
- 18 U.S.C. § 1028(a)(7) (Use of Identification Information)
- 18 U.S.C. § 1028(a)(7) (Use of Identification Information)
- U.S.C. § 1035 (False Statements Relating to Health Care Matters)
Medicare Fraud Waste & Abuse (FWA)

Many laws govern healthcare fraud, waste and abuse, among them:

- The Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b)
- Physician Self-Referral (“Stark”) Statute, 42 U.S.C. § 1395nn
- Criminal Health Care Fraud Statute, 18 U.S.C. Section 1347
- Health Insurance Portability and Accountability Act of 1996 (“HIPAA”)

Federal Anti-Kickback Statute

USC § 1320a-7b(b) – Criminal Statute

- Prohibits knowingly or willfully soliciting, receiving, offering, or paying any remuneration (including any kickback, bribe, or rebate) in order to induce or reward business that is payable under a federal health care program.
- Transactions among parties who refer to each other are subject to the AKS.
- If guilty, can result in incarceration 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
Anti-kickback Statute (cont’d)

- Under § 6402(f)(2) of the Affordable Care Act:

  “A person need not have actual knowledge of this section or specific intent to commit a violation of this section.” (emphasis added).

- “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 – “knowing and willful” – but not specific intent to violate this law.

- 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

Anti-kickback Statute (cont’d)

- **Safe harbors.** As the anti-kickback statute reflects, the scope of potential coverage under the law is extraordinarily broad. In recognition of this fact, in 1987 Congress authorized the Department of Health and Human Services, Office of Inspector General (OIG) to issue “safe harbors” for certain business arrangements and practices that while potentially a violation of law, would be permitted as long as certain safeguards are put in place to prevent fraud and abuse.

- Safe harbors are voluntary, not mandatory.

- While a given arrangement is not necessarily a violation of the anti-kickback statute if one or more of the elements in a safe harbor have not been met, a provider is effectively precluded from relying on a safe harbor as an absolute defense.

- The number of safe harbors to the federal anti-kickback statute is subject to change.
Anti-kickback Statute (cont’d)

Personal Services and Management Contracts Safe Harbor:

- (1) Written agreement signed by the parties.
- (2) Agreement covers and specifies all of the services the agent provides to the principal for the term of the agreement.
- (3) If services are part-time, the agreement specifies exactly the schedule of such intervals, their precise length, and the exact charge for such intervals.
- (4) Term of at least one year.
- (5) The aggregate compensation paid to the agent over the term of the agreement is set in advance, is consistent with fair market value in arms-length transactions and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made in whole or in part under Medicare, Medicaid or other Federal health care programs.
- (6) The services performed under the agreement do not involve the counselling or promotion of a business arrangement or other activity that violates any State or Federal law.
- (7) The aggregate services contracted for do not exceed those which are reasonably necessary to accomplish the commercially reasonable business purpose of the services. (emphasis added). 42 C.F.R. § 1001.952(d)(2014).

Anti-kickback Statute (cont’d)

Employment Safe Harbor:

- Must be a bona fide employee – refers to the IRS test of whether someone is an employee
- Often comes up in marketer/kickback cases where fees were commission or success based
- Key factors in prosecuted cases include:
  - Form of payment (hourly v. pure commission compensation).
  - Whether alleged employee had an office at employer’s location.
  - Whether alleged employee received any training.
  - Whether alleged employee set his or her own hours or worked full-time.
  - Whether employer paid all expenses of alleged employee.
Federal Physician Self-Referral ("Stark") Law
42 US § 1395nn – Civil Statute

- Prohibits a physician from making referrals for certain designated health services (DHS) to an entity in which the physician, or a member or his/her family, has an ownership/investment interest or with which he/she has a compensation arrangement, unless an exception applies.
- Potential penalties for violation:
  - Up to $15,000 for each claim submitted in violation of the law
  - Up to $100,000 for each scheme that violates the law
  - Denial of payment for DHS and refund of amounts paid
  - Treble damages
  - Exclusion from federal health care programs

Stark Law – (cont’d)

Key terms:
- Financial relationship = compensation, ownership or investment interests.
- DHS - Home health services are DHS, but Hospice services are not.
- Stark would apply if an HHA is physician-owned and will ever refer Medicare patients to the HHA. There is an exception for investments in rural HHAs, but it is very limited.
- Strict liability, civil statute. Violation results in obligation to refund all payments (by HHA!) and possible fines.
Stark Law (cont’d)

- Exceptions – similar to safe harbors under AKS
- Commonly used exceptions: personal service arrangements, office space lease, equipment lease, bona fide employment relationships (limited in Texas due to corporate practice of medicine), nonmonetary compensation, investment in a rural provider
- Personal Service Arrangements exception very similar to AKS safe harbor
- 42 CFR 424.22(d) expressly prohibits a physician/non-physician practitioner from certifying/re-certifying or establishing a plan of care if he or she has a financial relationship with an HHA, unless that relationship complies with a Stark exception

Federal False Claims Act – Civil Statute
31 U.S.C. §§ 3729-3733

- Forbids submitting for reimbursement a claim known to be false; making or using a false record or statement material to a false claim or obligation; conspiring to defraud by improper submission of false claims; or concealing, improperly avoiding, or decreasing an obligation to pay money to the government
- No proof is required of specific intent to defraud
- “Knowing” can mean actual knowledge or acting in deliberate ignorance or reckless disregard of truth or falsity
- A health care provider’s retention of an overpayment by a federal health care program may give rise to False Claims Act liability, if retained knowingly and otherwise in violation of the FCA
- Potential penalties for violation:
  - Fines of up to $11,000 per false claim
  - Treble damages
  - Exclusion from participation in federal health programs

-States that have adopted False Claims laws can also impose significant fines and penalties.-
The False Claims Act (cont’d)

- The FCA allows anyone to bring a *qui tam* (whistleblower) action under the FCA.
- The private parties who initiate such actions are called “relators”. Relators may share in any monies recovered as a result of their *qui tam* action. *Relators can receive between 15% and 25% of any recovery in a *qui tam* action where the government has intervened in the case.* In a non-intervened case, a relator may recover up to 30%. Consequently, there is a tremendous financial incentive to file and pursue these types of actions.
- Anyone initiating a *qui tam* case cannot be discriminated or retaliated against. The employee is authorized under the FCA to initiate court proceedings to make themselves whole for any job related losses resulting from any such discrimination or retaliation.
- *Under the ACA, a claim submitted in violation of the federal anti-kickback statute now automatically constitutes a false claim for purposes of the False Claims Act.*

Federal HIPAA Statute – Criminal Provisions

- HIPAA established the national Health Care Fraud and Abuse Control Program (“HCFAC”), which coordinates federal, state, and local law enforcement activities with respect to health care fraud and abuse
- HIPAA also enacted an additional prohibition of health care fraud (18 USC § 1347)
- Potential penalties include:
  - Up to ten years imprisonment, except:
  - If the violation results in death, life imprisonment
  - If the violation results in serious bodily injury, 20 years imprisonment
Criminal Health Care Fraud Statute

The Criminal Health Care Fraud Statute (18 U.S.C. Section 1347) prohibits knowingly and willfully executing, or attempting to execute, a scheme or artifice:

- To defraud any health care benefit program; or
- To obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program;
- in connection with the delivery of or payment for health care benefits, items, or services.

Proof of actual knowledge or specific intent to violate the law is not required. Penalties for violating the Criminal Health Care Fraud Statute may include fines, imprisonment, or both.

Other Federal Guidance – OIG Compliance Materials

- OIG has issued numerous guidance documents on implementing compliance programs in various health care fields
- October 1999 – Compliance Program Guidance for Hospices, [https://oig.hhs.gov/authorities/docs/hospicx.pdf](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/fraud/docs/alertsandbulletins/hospice.pdf](https://oig.hhs.gov/fraud/docs/alertsandbulletins/hospice.pdf)
- August 1995 – OIG Special Fraud Alerts: Home Health Fraud, [https://oig.hhs.gov/fraud/docs/alertsandbulletins/081095.html](https://oig.hhs.gov/fraud/docs/alertsandbulletins/081095.html)
OIG Compliance Program Guidance
Home Health Agencies

- Compliance Guidance discusses numerous potential risk areas:
  - 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

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
  - especially important with respect to independent contractors responsible for marketing activities and contracts with medical directors.
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 the billing … and marketing processes.”
- Topics should include general prohibitions on paying or receiving remuneration to induce referrals, government and private payor reimbursement principles, and proper documentation of services.
  - 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
- Audits should be designed to address the home health agency’s compliance with laws governing kickback arrangements, the physician self-referral prohibition, coverage and payment laws and regulations, employee screening, etc.

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

- 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 FCA
OIG Compliance Program Guidance
Hospices

- Like home health agency guidance, hospice guidance discusses a number of risk areas, including:
  - Arrangements with another health care provider the 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

- 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
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

OIG Fraud Alert: Fraud and Abuse in Nursing Home Arrangements with Hospices – March 1998

“The OIG has observed instances of potential kickbacks between hospices and nursing homes to influence the referral of patients. In general, payments by a hospice to a nursing home for “room and board” provided to a Medicaid hospice patient should not exceed what the nursing home otherwise would have received if the patient had not been enrolled in hospice. Any additional payment must represent the fair market value of additional services actually provided to that patient that are not included in the Medicaid daily rate.”

Specific practices which are suspected kickbacks include:
- A hospice offering free goods/below fair market value good to induce a nursing home to refer patients
- A hospice paying “room and board” payments to the nursing home in amounts in excess of what the nursing home would have received directly from Medicaid had the patient not been enrolled in hospice.
- A hospice paying amounts to the nursing home for “additional” services that Medicaid considers to be included in its room and board payment to the hospice.
- Reciprocal referral relationships – hospice to nursing home in exchange for nursing home to hospice
- A hospice providing free (or below fair market value) care to nursing home patients, for whom the nursing home is receiving Medicare payment under the skilled nursing facility benefit, with the expectation that after the patient exhausts the skilled nursing facility benefit, the patient will receive hospice services from that hospice.
- A hospice providing staff at its expense to the nursing home to perform duties that otherwise would be performed by the nursing home.
OIG Bulletin, Offering Gifts and Inducements to Beneficiaries – August 2002

- 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](https://oig.hhs.gov/fraud/docs/alertsandbulletins/sabgiftsandinducements.pdf)

OIG Bulletin, Offering Gifts and Inducements to Beneficiaries (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.

- 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

- Discusses practices that OIG has found in investigations and studies of home health agencies.
- 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

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-visiting physician companies upcoding patient visits and billing for care plan oversight services not actually rendered

- Discusses settlement with 12 individual physicians, with focus on medical director payments
  https://oig.hhs.gov/compliance/alerts/guidance/Fraud_Alert_Physician_Compensation_06092015.pdf
- Compensation relationships discussed included:
  - Payments varied with 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

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
- 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.
OIG Work Plan

- Open audits or investigations:
  - Accuracy of Falls Reporting in Home Health OASIS Assessments
  - Electronic Visit Verification System for Medicaid In-Home Services
  - Home Health Agencies’ Emergency Communication Plans: Strengths and Challenges Ensuring Continuity of Care During Disasters
  - Audit of Home Health Services Provided as Telehealth During the COVID-19 Public Health Emergency

Texas laws – just a sampling…

- Texas Solicitation of Patients Act (Tex. Occupations Code § 102.001 et seq.) – analogous to Anti-kickback statute and permits any arrangement or practice permitted by federal AKS, but applies to ALL PAYORS and all licensed professions
- Texas Physician Solicitation prohibition (Tex. Occupations Code § 165.155) – analogous to federal AKS but specific to physicians
- Texas Human Resources Code Ch. 32 – analogous to Federal AKS but applies specifically to Medicaid and incorporates federal AKS safe harbors
- Texas Medicaid Fraud Prevention Act (Tex. Human Resources Code § 36.001 et seq.) – analogous to federal False Claims Act
- Several Texas self-referral laws like the Stark Law:
  - Tex. Occupations Code § 105.002 – governs physician referrals to niche hospitals if have financial relationship
  - Tex. Health & Safety Code § 142.019 – physician cannot refer to HHA/hospice if would violate Stark Law
- 1 Tex. Admin. Code § 371.1669 – incorporates Stark law prohibition and applies to physician referrals for DHS payable by Medicaid
- 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.
Texas Guidelines on Marketing

- Texas HHSC issued guidelines for marketing for providers enrolled in Texas Medicaid, CHIP programs
- Prohibitions:
  - Unsolicited personal contacts such as direct mail/email, phone or in person
  - General dissemination by TV, radio, newspaper, internet, billboard is ok
  - Offering inducements or giveaways of more than $10 value
  - Offering gifts or inducements designed to influence individual’s choice of provider
  - Reading level not greater than 6th grade
  - Available in English & Spanish, plus others upon request
- 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.

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8. Self-Review Checklist/Questions

1. Does the Marketing Material include a general statement, or a list of all insurances accepted rather than only listing Medicaid?
   - If yes → this meets requirements.

2. Is the Marketing Material sent to everyone within the zip code?
   - If yes → this meets requirements.

3. Is the Marketing Material strictly to promote health education?
   - If yes → this meets requirements.

4. Is the Marketing Material at or below the sixth grade reading level?
   - If yes → this meets requirements.

5. Does the marketing include a giveaway valued at more than 10 dollars?
   - If yes → this is a prohibited provider marketing.
Audits

Primary Sources of an Audit:
- Predictive Modeling / Data Mining. As Chapter 2, Sec. 2.3 of the MPIM details: “Claims data is the primary source of information to target abuse activities.”
- Complaints. These can include “complaints” filed by beneficiaries, physicians, other home health / hospice / personal care agencies (such as competitors), disgruntled current and former employees.
- Overpayment data. This may be based on a provider’s “error rate,” the provider’s history of repeated overpayments or similar data.
- Referrals. Audits and investigations of health care fraud are often based on referrals from CMS contractors (other ZPICs, SMERCs, MACs, etc.), State MFCUs, and other law enforcement entities. Notably, private payors are also referring cases to the government.
- Reports. OIG and GAO regularly issue reports addressing areas of concern. These reports are often a harbinger of ongoing and future enforcement initiatives.
- State Licensing Boards. In many states, State Medical Boards, Nursing Boards, Pharmacy Boards and other entities responsible for handling State licensing responsibilities are regularly making audit referrals to CMS.

More Examples of Problematic Conduct
- Illegal solicitation of referrals
- Kickbacks / disguised kickbacks and bribes
- Gifts to patients
- Confusing Stark with the Federal Anti-Kickback Statute
- Identity theft
- Failure to conduct exclusion screening
- Billing for the services of unlicensed individuals
- Failure to provide proper supervision
- Filing claims for dead people
Tips and Best Practices

- Educate yourself - understand the AKS, Stark, False Claims Act, and relevant Texas laws.
- Retain counsel. Remember, everything you say is evidence.
- **Implement a Compliance Plan!**
  
  If you don’t have a Compliance Plan in place – get one! Do you take Medicaid? If so, you better have a plan in place.

- Texas Medicaid Providers must have a Compliance Program containing the core elements as established by the Secretary of Health and Human Services referenced in § 1866(j)(8) of the Social Security Act (42 U.S.C. § 1395cc(j)(8)), as applicable.
- You attested you have a compliance plan when you enrolled or revalidated. You may have checked the box “yes” without even realizing what a compliance program is or what is required under this section.
- Many private payors are also now including a “compliance” requirement in their contracts.

Tips and Best Practices

- **Know the ground rules and high-risk issues!**

  - **Coverage requirements** – Review applicable Local Coverage Determination (LCD), National Coverage Determination (NCD) and Medicare Benefit Policy Manual (MBPM) requirements and make sure your staff know where to find them.
  - Review top claim denial reasons & conduct self-audits:
    - Palmetto publishes its top denial reasons here: [https://palmettogba.com/palmetto/jmhhh.nsf/T/Medical%20Review--Denials](https://palmettogba.com/palmetto/jmhhh.nsf/T/Medical%20Review--Denials)
    - For Hospice, from January – March 2022, Palmetto’s top denial reasons were--

<table>
<thead>
<tr>
<th>Rank</th>
<th>Denial Code</th>
<th>Denial Description</th>
<th># Claims</th>
<th>% Claims Denied</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>12345</td>
<td>The Notice of Election is Invalid because it doesn’t Meet Statutory or Regulatory Requirements</td>
<td>466</td>
<td>35.0</td>
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<tr>
<td>2</td>
<td>67890</td>
<td>Amt Denied – Submitted Records Not Substantiated</td>
<td>318</td>
<td>102</td>
</tr>
<tr>
<td>3</td>
<td>09876</td>
<td>Not Hospice, Appropriate</td>
<td>78</td>
<td>9.3</td>
</tr>
<tr>
<td>4</td>
<td>56789</td>
<td>Face-to-Face Encounter Requirements Not Met</td>
<td>85</td>
<td>7.9</td>
</tr>
<tr>
<td>5</td>
<td>98765</td>
<td>Hospice GIP Reduction – Services Not Reasonable/Necessary</td>
<td>65</td>
<td>6.6</td>
</tr>
</tbody>
</table>

Any of these can trigger an investigation for fraud, waste or abuse if your error rate is higher than your peers!
Tips and Best Practices

For Home Health, from January to March 2022, Palmetto’s top denial reasons were--

<table>
<thead>
<tr>
<th>Rank</th>
<th>Denial Code</th>
<th>Denial Description</th>
<th># Claims</th>
<th>% Claims Denied</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>59900</td>
<td>Auto Denial – Requenod Records Not Submitted</td>
<td>1,050</td>
<td>45.8</td>
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<tr>
<td>2</td>
<td>57F3F</td>
<td>Face-to-Face Encounter Requirements Not Met</td>
<td>591</td>
<td>21.8</td>
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<tr>
<td>3</td>
<td>5F033</td>
<td>No Plan of Care or Certification</td>
<td>272</td>
<td>11.9</td>
</tr>
<tr>
<td>4</td>
<td>5F040</td>
<td>Info Provided Does Not Support the MW for This Service</td>
<td>104</td>
<td>4.5</td>
</tr>
<tr>
<td>5</td>
<td>5F402</td>
<td>Info Provided Does Not Support the MW for Therapy Services</td>
<td>15</td>
<td>4.5</td>
</tr>
</tbody>
</table>

Any of these can trigger an investigation for fraud, waste or abuse if your error rate is higher than your peers!

Tips and Best Practices

Physician Relationships

➢ Ensure that every relationship with a physician is documented and reviewed by a healthcare attorney.
➢ Document valid business rationale and fair market value of services.
➢ Medical directors should be compensated solely for clinical and admin services. There should be no link to referrals or admissions.
➢ Physicians should document time to support payment for medical director services.
➢ Review medical director invoices to ensure that services provided, and hours worked are reasonable
➢ Train medical directors on eligibility criteria, Medicare definitions, and compliance with law
➢ Monitor relationships with outside referring physicians, their offices, and marketers as part of your compliance program.
Tips and Best Practices

Physician Relationships

- Screen your physician referral sources and medical directors monthly
  - HHS-OIG LEIE – https://exclusions.oig.hhs.gov/
  - Texas HHSC Exclusions Database - https://oig.hhsc.state.tx.us/oigportal2/Exclusions
  - CMS Ordering & Referring Database - https://data.cms.gov/Medicare-Enrollment/Order-and-Referring/qcn7-gc3g/data

- Screen your employees and independently contracted staff.
  - Medicare and Medicaid providers and suppliers should screen monthly.
  - OIG’s List of Excluded Individuals and Entities (LEIE), the General Services Administration’s System for Award Management (SAM) List of Parties Debarred from Federal Programs, and Texas OIG exclusion database must be checked with respect to all employees, medical staff and independent contractors

- In Texas, HHSC-OIG is very aggressive in its approach towards compliance.
- The screening of employees, contractors and business associates is perhaps the quickest and easiest compliance measure you can implement (if you have not already screened your staff).
Tips and Best Practices

Marketing Staff

- Ensure that your employees are truly employees – consider IRS definition
  - Behavioral control: Does the company control or have the right to control what the worker does and how the worker does his or her job?
  - Financial control: Are the business aspects of the worker’s job controlled by the payer? (these include things like how worker is paid, whether expenses are reimbursed, who provides tools/supplies, etc.)
  - Type of Relationship: Are there written contracts or employee type benefits (i.e. pension plan, insurance, vacation pay, etc.)? Will the relationship continue and is the work performed a key aspect of the business?

- Carefully evaluate compensation plans for marketing 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 – fixed fee determined in advance
  - Contracted services should be valid services and not a “cover” for referrals

Tips and Best Practices

Marketing Staff

- 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
Tips and Best Practices

**Marketing Staff**

- Carefully evaluate your marketing materials and approach to patients and remember Texas law limits direct contact marketing.
- Ensure patients and family members understand purpose of home health and hospice.
- Avoid giving gifts/freebies to patients or their 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!**
Questions?

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